

**INTERESTS AND IDEAS IN HEALTH POLICY:
THE FATE OF HOSPITAL RATE SETTING IN FOUR STATES**

by

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ABSTRACT**INTERESTS AND IDEAS IN HEALTH POLICY:
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From its once pre-eminent position in state health policy, hospital rate setting has declined in use to a handful of states today. This study examines prospective hospital rate setting in four states that established aggressive programs. The decisions to deregulate by Massachusetts and New Jersey state governments, along with an anticipated decision in New York in 1996, are examined. Maryland state government's choice not to deregulate is also explored. Two rival theories are used as potential explainers of these developments: the theory of economic regulation emphasizing the role of interest groups, and the punctuated equilibrium model of policy change emphasizing policy ideas.

Results: Hypotheses of the theory of economic regulation are not supported. While shifts in interest group support for regulation preceded deregulation, clear evidence that rate setting benefited hospitals more than consumers was not found; public officials, were not found to only respond to interest group agendas. Hypotheses of the punctuated equilibrium model are supported. Identifiable "policy ideas" could be clearly associated with rate regulation and the move to deregulation; clear institutional change is associated with each deregulation. New actors were identified who helped to undermine the rate setting "policy monopoly."

Factors associated with deregulation include: 1) a conflict with growing managed care systems in rate setting states; 2) political change from Democratic to Republican control in key governmental power centers; 3) regulatory failure and increasingly Byzantine reimbursement rules that undermined support; and 4) changed interest group support for deregulation. Maryland's record stands in contrast to the deregulated states.

Lessons from rate setting include: 1) deregulation signifies an evolution to more advanced forms of prospective payment, chiefly capitation instead of per diem or per case methods; 2) the decline indicates a shift to a different role for state government in health regulation, including an explicit rejection of the public utility model; 3) rate setting's history demonstrates the broad ability of regulated entities to manipulate reimbursement systems; and 4) the experience indicates some strengths in state government to maintain systems to control costs and improve access.

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To Helen and Joseph McDonough
with love.

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Special thanks go to the 60 interview subjects in Maryland, Massachusetts, New Jersey and New York. Whether they knew me beforehand or not, they opened up their thoughts to me in ways that I never could have predicted beforehand -- and their marvelously candid quotes that I have used liberally throughout this study are the proof of their openness. The participants are listed in the study's appendix.

Thanks also to funders who gave me the resources to complete this study in such a rapid period of time. These include the Health Care Financing Administration of the U.S. Department of Health and Human Services, and the Michigan Blue Cross and Blue Shield Foundation. Their support was invaluable in enabling me to complete the interviews quickly, all of which were done in person by the author in the subject's state. Thanks also to the Pew Charitable Trust for their support of this doctoral program.

Finally, thanks to my children, Devlin and Amy, who put up with intolerable absences and distractions during 24 months of course work, and during another 18 months of dissertation madness. I'd like to say now, "I'm going to Disneyworld", but that may just have to wait for another re-election campaign to go by first.

PREFACE

Professor Leon Wyszewianski told me early in my graduate studies at the University of Michigan School of Public Health that much doctoral education consists of "getting things out of your system that have been hanging around there for too long." Welcome to my doctoral dissertation. At least to his point, there should be little disappointment.

Since 1985, I have served as a state representative for the Commonwealth of Massachusetts, representing inner city Boston neighborhoods. By a series of coincidences -- including supporting the winning side in a Speaker's fight -- I became a member of the Joint Committee on Health Care in 1985 as the sole Boston representative. As I told people at the time, I barely knew the difference then between Medicare and Medicaid.

In the Commonwealth's health policy circles in that period, key interest was focused on the strategizing and battles related to the all-payer hospital rate regulation system. If you were connected to a hospital, you wanted maximum flexibility to increase charges to sustain your institution. If you were associated with insurers, labor unions, or the business groups that involved themselves with the issue, you wanted to keep the pressure at the maximum possible level to lower costs in the most expensive hospital system in the world. If you were a consumer or a progressive legislator, you wanted to keep costs down to expand access, and to lay the groundwork for future battles for universal coverage.

For six years, I engrossed myself in learning the ins and outs of an impossibly complex regulatory model, trying to rationalize it and make it work, trying to hold onto a road map of the promised to lead us all to a universal entitlement to care for all Massachusetts residents. In 1991, it all fell apart. First, a newly elected Governor set a direction for market oriented health economics. Then, some of the key interest groups that had sustained the regulatory system for

so long began to move away from their prior positions of support. Finally, the House and Senate rejected my arguments in favor of either an alternative regulatory model (Maryland's) or a single payer alternative, and embraced the logic of deregulation and the market. At that time, we were the only one of the four major rate setting states that moved in this direction, though New Jersey followed in the next year.

Before, during, and after that legislative conflict, the curious interplay between interest group agendas and policy ideas had fascinated and perplexed me. I recall reading Feldstein's *The Politics of Health Legislation* in 1990 or 1991 and becoming thoroughly convinced of his argument that the self interest model could explain nearly everything while the public interest model was practically useless. In the context of the State House, interest groups and lobbyists were everywhere and their influence seemed boundless. By contrast, the health services researchers, whom I had begun to meet through the National Center for Health Services Research starting in 1985, were nowhere. Their research seem to be noticed and embraced only when it concurred with beliefs already held, and ignored and scorned in the opposite instances.

In the course of my doctoral studies at the University of Michigan, I explored many ideas and opportunities for research before winding my way back to the issues and themes that have been with me throughout my legislative career. The process has led me to findings and conclusions that are different than those that I held when I first showed up at the School of Public Health in Ann Arbor in September, 1992.

In brief, some of the worst predictions about the effects of deregulation never occurred, and some of the positive predictions have come to pass. We have seen considerable reshaping of the hospital sector, but without the massive closings that were predicted. Costs are still high, but not as high as they were at the end of regulation. Hospitals have shifted their focus from gaming state government to determining their own fates based on their ability to survive in a fast changing and merciless market. Access has worsened considerably, but not

necessarily because of the move to deregulation. Overall, what I fought so hard against has been a mixed blessing, but on balance, a benefit.

Meanwhile, interests do not appear quite as fearsome as they did in prior days. To be sure, they are not to be ignored, provoked, or messed with unnecessarily -- when strong groups are strongly united, they can still kill almost anything in their paths, as they recently did to my *latest* proposal for a minimal health care employer mandate. But they can also be understood, worked with, and helped in ways that make real progress possible. Most importantly, when policy ideas are on the table in compelling and immediate ways, it is often the interests who must learn to accommodate and adapt. It's not just ideas that matter in health policy, but it's not just interests either.

This study is the result of my pilgrim's progress in grappling with the meaning of state rate regulation's demise, and with the eternal interplay between interests and ideas, centered on the dynamic and hyperactive field of health care policy.

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CHAPTER I

INTERESTS AND IDEAS IN HEALTH POLICY:

AN OVERVIEW OF THE STUDY

In 1972 and 1973, Congress passed two distinctly different laws to attempt largely untried methods at controlling rapidly growing public and private health care expenditures. First, in Section 222 of the 1972 amendments to the Social Security Act (PL 92-603), Congress gave States the authority to establish prospective rate setting programs with federal participation to control hospital costs. Second, in the 1973 Health Maintenance Organization Act (PL 93-222), Congress provided incentives and guidelines to encourage the development of prepaid group practices to control overall health care expenditures.

Though the long-term impact of each statute was far from certain at the time of enactment, by the early 1980s it seemed clear that the experiments with the prospective reimbursement law had made the far greater mark. President Jimmy Carter attempted to impose this form of prospective rate setting on all acute hospitals across the nation in his ill-fated 1979 hospital cost containment proposal. By 1981, more than 30 states had established some form of prospective hospital rate setting, and a subset were beginning to experiment with mandatory controls on all public and private payers. [1]

Despite the Reagan Administration's coolness to rate setting, Congress passed further amendments to the Social Security Act in 1983 (PL 98-21) directing the Health Care Financing Administration to grant Medicare waivers to states seeking to establish all-payer prospective rate setting systems. In that same Act, Congress also mandated the

development of the Prospective Payment System, incorporating diagnosis related groups (DRGs) as the national reimbursement mechanism for Medicare inpatient hospital fees -- a system modeled after New Jersey's pioneering hospital rate setting program. The Medicare Resource Based Relative Value Scale, a physician payment system that was established later that decade, represents another national form of prospective rate setting that has expanded throughout the health system. Beginning in 1980, empirical studies began to be published for the first time that demonstrated that states with mandatory rate setting programs had a pattern of lower hospital cost increases than states without such regulation. [2]

By contrast, HMOs had grown to cover only about four percent of the U.S. population in 1980, far less than expectations at the time of the HMO Act's adoption. [3] In 1981, the Reagan Administration eliminated all further federal development grants to HMOs leaving their future prospects very much in doubt. One major 1983 study of the 1973 HMO Act and subsequent federal statutes concluded that no significant surge in HMO growth could be expected for the foreseeable future. [4]

By 1995, the landscape had changed considerably. Most states had dismantled their rate setting structures, and of the four states that had established mandatory statewide controls in the 1970s on all public and private payers, only two still left them in place, with one of those moving rapidly to deregulation. HMOs, by contrast, had grown from 236 in number in 1980 to 546 in 1992, and from about 9.1 million covered lives in 1980 to 41.4 million in 1992, or more than 18 percent of all covered lives [5]. While some mild interest in government-managed, prospective rate setting persisted as a policy option through the early 1990s, it was the HMO and managed care that formed the organizational core of President Bill Clinton's proposed Health Security Act in 1994 as well as Republican Congressional proposals to revamp the Medicare program in 1995.

What accounts for the demise of prospective rate setting as central policy option in state health care cost containment? What political and economic theories can help to explain rate setting's fall from grace? What role did interest groups and policy ideas play in the transformation? What lessons can be learned for future health policy making from rate setting's rise and fall? How and why did the disposition of rate setting vary from state to state? What can rate setting's demise tell us about the interplay between interests and ideas and health policy? These are the central questions posed by this study.

General Statement of Objectives

Using a multiple case study approach, this investigation will examine economic and political factors leading to the demise of mandatory hospital rate setting in Massachusetts in 1991 and in New Jersey in 1992. Also examined will be factors leading to rate setting's predicted demise in New York State in 1996, as well as factors accounting for the continuation of mandatory rate regulation in Maryland.

Specifically examined will be the theory of economic regulation and the punctuated equilibrium model of policy change. This study will examine what these two rival theories can explain about the disposition of rate setting in these four states. In economic terms, we ask whether the treatment of rate setting in these four states is consistent with assumptions about the rational behavior of interest groups and public officials as outlined in the theory of economic regulation, and especially as it relates to cases of deregulation? In political terms, we ask whether a longitudinal model of policy change that emphasizes the role of ideas in shaping policy development can help to better understand the evolution and outcome of this regulatory tool? What can the experience of these four states offer in understanding the future of rate setting as a regulatory tool in health care cost containment? What can the work of these states offer in examining the continuing dynamic

between regulatory and competitive approaches to health care cost control? Finally, what can the rate setting case histories from the four states tell us about the broader interplay between interests and ideas in health policy making?

Specific Aims/Theoretical Models

The three central research questions for this study are: *What factors help to explain the demise of mandatory hospital rate setting in Massachusetts in 1991, in New Jersey in 1992, and the predicted deregulation in New York in 1996, as well as the continuation of mandatory rate setting in Maryland? To what extent can these outcomes be explained by the theory of economic regulation and the punctuated equilibrium model of policy change? Finally, what does this experience tell us about the interplay between interest groups and policy ideas in health policy making?*

State based hospital rate setting is defined as the prospective establishment of rates of payment by major payers for hospital services, regulation performed by the State or some other approved entity or group of entities, and having either voluntary or mandatory compliance. Rate setting for hospitals can be traced back to the 1950s in two states, though the practice did not proliferate widely until the 1970s when it spread in a variety of forms to more than 30 states. Four states (Maryland, Massachusetts, New Jersey, and New York) adopted mandatory, state administered rate setting on all public and private payers in the 1970s and 1980s.

In numerous empirical studies, mandatory rate setting has been found to lower the rate of inpatient hospital expenditure growth relative to non-rate setting states on a per admission, per day, and per capita basis. Substantial differences from state to state and time period to time period have also been observed. [6] Chapter two of this study will review the financial performance of rate setting systems in greater detail. Chapter four

will review the financial performance in the four subject states.

All state-based rate setting systems vary markedly from one to another in structural details, including the mandatory programs in the four states previously mentioned. Five items characterize the four states included in this study: 1) the rate setting system was operated by a state agency; 2) compliance with the system was mandatory as opposed to voluntary; 3) all public and private payers (Medicare, Medicaid, Blue Cross, commercial payers) were at one time subject to the same set of rules; 4) the system had actively been in operation since 1976. [7] These characteristics provide the rationale for the selection of the four study states.

One particular regulatory feature will be explored in detail, namely, the extent to which health maintenance organizations were permitted to operate outside of the regulatory framework by negotiating discounts for hospital services below charges permitted to Blue Cross and other insurers. Only one of the four subject states, Massachusetts, permitted unlimited discounting, thus creating a disequilibrium between HMOs and other payers in those states. However, New Jersey and New York permitted forms of discounting that, as we will see, undermined the stability of their systems. The extent to which this feature played a role in undermining the larger regulatory structure will be an important aspect of this investigation.

Beyond discounting, special attention will be paid to the growth and development of managed care in general, and HMOs in particular in the four target states. The prospective rate setting systems in these states all began well before HMOs and managed care gained a significant market foothold. The rapid development of managed care in the subject states has played a significant role in the demise of rate setting. This study will also address not just the demise of rate setting in three states, but also its continuation in one other state.

In attempting to account for these differences among the four subject states, special attention will be paid to two rival theories: first, the theory of economic regulation, and second, the punctuated equilibrium model of policy change. Alternative theories are explored in this study not to create an either/or competition, but in recognition that the use of different "conceptual lenses" is particularly useful in case study analysis. [8]

The Theory of Economic Regulation: While the rival theory -- the punctuated equilibrium model of policy change -- is quite recent in political science literature, the theory of economic regulation has a long history generally and in health policy specifically. [9] [10] According to this view, regulatory policies and structures are created for the sole or principal purpose of monopolizing the regulated sector. "... (R)egulation enables what is or would be a competitive industry to act as though it were in fact a monopoly. The impetus for regulation, or for the capture of the regulatory agency by the industry it is meant to regulate, comes from the industry's desire to use the regulatory process as a vehicle for charging higher prices, restricting its output, raising its profits, and protecting itself from possible competitors." The driving force behind regulation is the set of interests the system is meant to protect. [11]

The theory of economic regulation model has also been seen as useful in explaining cases of deregulation. According to the theory, the principal reason why industries may lose their regulatory protection is because of change in the relative political support for continued regulation when the benefits offered to legislators by opponents of regulation exceed the benefits offered by the proponents. [12]

Use of this model can be helpful in understanding both the array of forces that contributed to the establishment and maintenance of state-based rate setting for more than two decades, but also to its demise. Two key sets of interests will be examined in detail.

The first group is composed of those interests that supported the establishment of rate setting: hospitals, insurers, businesses, labor, and government; how their positions may have changed over time will be observed. Of special interest will be the changing nature of government's own interest in health sector rate regulation. The second group is composed of those interests who were not players at the time the systems were created, chiefly managed care entities such as HMOs as well as new legislative and executive branch officials. Both the change in their positions and the change in their relative political and market strength have relevance to this investigation.

Punctuated Equilibrium Model of Policy Change: Baumgartner and Jones use longitudinal analysis of policy development to devise a model of change that explains the emergence and recession of policy issues from the public agenda. [13] According to their model, new institutional structures -- such as prospective rate setting -- are created during brief periods of volatile change when policy ideas are under challenge and previous policy monopolies have become unstable. The new institutional forms, once dominant, may remain in place for decades, structuring participation and creating the illusion of stability and equilibrium. Eventually, the generation of new ideas makes these existing policy monopolies unstable, and subject to elimination or substantial alteration during the next period of volatile change.

Baumgartner and Jones suggest two elements that distinguish their model from other policy development frameworks. First, they emphasize that policy clashes are frequently strategic struggles over the definition of issues and the battle of ideas. It is both the emergence of new ideas and the strategic redefinition of the "problem" that determine the field of conflict in the next period of volatility. Second, they emphasize a long-run view of the policy process that increases one's awareness of the long-term fragility of most subsystems and regulatory structures.

Their perspective is helpful in examining a policy process such as rate setting that has survived over a period of more than 20 years. A similar examination of hospital rate setting conducted in 1985 would have led to vastly different conclusions than one conducted in 1995. Thus the longitudinal perspective is important and helpful. Their emphasis on the clash of ideas is also relevant in the interplay between mandatory rate setting versus managed care, or regulation versus competition in a broader sense. A major conclusion of this investigation is that managed care and HMOs represent a key manifestation of the new policy "idea" that for now appears to have challenged and toppled all but one of the state rate setting policy monopolies.

One particular theme of this study is that the *form and structure* of public sector regulation -- more than its mere existence -- will determine its outcome and impact. While the rate setting systems in the four subject states, viewed from afar, seem alike and uniform, up close they are noteworthy for many important design differences among them. Some of these discrete differences played important roles in the fate of rate setting in each state. In exploring this theme, it is hoped to advance understanding in the continuing debate between competition and regulation in the health care sector. As Luft notes, "neither strategy has ever been fully implemented. Instead, past and current policies have included combinations of regulatory and competitive efforts as well as components that are difficult to classify." [14]

Each of the regulatory systems in the four states differed in important ways in their respective creation and development processes. The unique political culture and pre-existing market structure in each state had a large impact on each system's progress. This will be especially apparent in examining the interaction of each system with the state's HMO community. By examining the unique aspects of each state, it is hoped to highlight both the differences and similarities.

Organization of the Study

Chapter two provides a review of the relevant literature concerning state hospital rate setting between 1975 and 1995. All aspects of prospective rate regulation will be examined. Special emphasis is given to the literature describing the substance and development of the theory of economic regulation and the punctuated equilibrium model of policy change. Attention is also paid to the literature on regulation and competition to understand the interaction between rate setting and other hospital cost containment forms.

The methodology and structure for this investigation is outlined in detail in chapter three. This investigation utilizes the multiple case study design as outlined by Yin who provides a rigorous model for this type of examination in order ensure maximum validity and reliability. [15]

Analysis of basic descriptive data, and the background case histories of rate setting in the four subject states, are presented in chapter four. Data will be examined concerning the growth of health and hospital costs on per capita and per admission bases in the subject states, along with HMO membership growth between 1980 and 1993. Because the group of rate setting states is so small, and because many interrelated variables account for the shaping of public policy in this area, quantitative analysis of data will be only one limited portion of this study. Also presented will be information on several political variables relevant to the states. Many empirical studies have examined the performance of prospective hospital rate setting over its twenty year history. In this chapter, the particular performance of rate setting and of the health systems in general in the four subject states will be explored.

Chapter five examines evidence to confirm or reject specific hypotheses related to the theory of economic regulation and the behavior of key interest groups and stake holders. In particular, evidence is examined concerning the behavior and conduct of

hospitals, Blue Cross plans, commercial insurers, health maintenance organizations, business groups, labor unions, consumers, regulatory agencies, and state health purchasing entities such as Medicaid. Each hypothesis will be examined based on the data and evidence presented.

Chapter six explores evidence related to the specific hypotheses of the punctuated equilibrium model and the role of ideas in the rate setting stories. The key sources of evidence for this chapter and for chapter five will be: 1) interviews with principals from the previously mentioned constellation of interest groups in each state; 2) documentation of official and unofficial proceedings in each state, as well as journalistic accounts and letters; 3) archival records of statutes, regulations, and other critical documents; and 4) some direct observation of administrative proceedings in the two remaining rate setting states.

The final chapter seven summarizes the findings, draws conclusions from the investigation, applies these findings to the theory of economic regulation and the punctuated equilibrium model of policy change, and identifies further areas for future potential research.

Applied/Policy Significance

As noted, a significant amount of research, empirically based and otherwise, has been conducted in the area of state-based hospital rate regulation. A large body of literature has examined the relationship between regulation and competition in health care in a variety of forms. Similarly, much research has been conducted examining the development of managed care in states. Virtually all of the empirical literature on state rate setting used data from before 1985. No empirical research has studied the performance of rate setting systems in the period 1985 to 1995.

This investigation differs from others in several respects. First, no research to date has explored the specific reasons for the abandonment of rate setting among these mandatory systems, deregulations that occurred within five years of each other after about 20 years of continuous operation. Some reports have discussed the cessation in one individual state, but none have looked for patterns and points of commonality among the four. Similarly, none has examined the policy lessons or implications of this significant policy shift.

Second, no research has applied either the theory of economic regulation nor the punctuated equilibrium model to a discussion of the creation and dissolution of rate setting in the affected states. The interplay between interests and ideas, explored in other economic sectors, has been given little treatment in health policy literature. It is hoped that this study can contribute to a deeper understanding of both the rate setting phenomenon and the relevant political and economic theories.

Third, no research has explicitly examined the relationship between state rate regulation and HMO development in those affected states. It is hypothesized that the interaction between these two models is vitally important in understanding what happened in at least several of the affected states. Findings here could be important in opening up avenues of further research.

Finally, there is an assumption in much literature on competition and regulation in health care that these two forms are incompatible and conflicting, placing them in an either/or context. As noted by Luft above, this view is overly simplistic. The intent of this research is to move beyond this restricted choice to a more realistic framework. This framework recognizes that neither pure competition nor total regulation are desirable policy options, and that the appropriate mix between the two will change during different periods. It is hoped that this study will contribute toward better understanding of

conditions where regulation and competition be more compatible.

Personal Involvement: Finally, it must be noted that the author comes to this investigation with a history of prior involvement in this particular policy matter. Continuously since 1985, as a member of the Massachusetts House of Representatives, I have been deeply involved in matters of state health policy, as a supporter of reauthorizations of our hospital rate regulation laws in 1985 and 1988, and as a legislative opponent of deregulation in 1991. I have also been deeply involved in legislative matters relative to managed care and HMOs in Massachusetts as well as a variety of other health policy matters during the same time period. While I do not believe that this personal history creates any bias in the findings of this study, indeed numerous conclusions of this study run counter to my prior policy positions as a legislator, this information is presented for the benefit of readers.

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CHAPTER II

LITERATURE OVERVIEW

A substantial body of literature has examined empirically the structure and performance of state-based hospital rate setting. Other large bodies of literature have examined the contrasting approaches of the role of self interest and rational choice as embodied in the theory of economic regulation and the role of ideas as discussed in the punctuated equilibrium model of policy change. This literature overview will describe the history of rate setting, its performance on cost, quality, productivity and other indicators, and its place in the broad debate on regulation versus competition. The two rival theories which serve as the conceptual models for the investigation will be discussed in turn.

A Brief History of Rate Setting

The Rise: The earliest examples of rate regulation -- albeit voluntary -- for hospital cost control date back to 1948 in Southwest Ohio and 1959 in Indiana. The first example of mandatory regulation began in New York in 1970. [1] By 1980 more than 30 states utilized some form of prospective rate setting, termed "the center of the policy paradigm for controlling health care costs during the 1970s." [2] Throughout the first half of the 1980s, state governments continued to adopt expanded and more rigorous programs, even as the health policy community held a heated debate over rate setting's merits. [3]

Some researchers have attempted to identify those states more likely to adopt *rate* setting, though the studies are weakened by the small number of affected states. Higher personal per capita income, higher population density, higher physician to population ratio, higher hospital bed to population ratio, and high market shares for Blue Cross and Medicaid all have been identified as potential indicators. [4] In addition, high costs per admission and per capita have been found to characterize rate setting states. [5] Another study utilizing regression analysis identified liberal states with budget deficits and large Medicaid hospital expenses as most likely to adopt such programs. [6] (Descriptive data on all of these measures both nationally and in the subject states is detailed in chapter four.)

As described in chapter one, the federal government was an active promoter of this trend, beginning with amendments to Social Security Act of 1972 that encouraged states to experiment with rate setting (PL 92-603, Section 222), and culminating in 1983 amendments directing HCFA to grant waivers to states to experiment with all-payer rate setting systems. While each national administration pursued its own distinct approach, "throughout the 1970s, the federal government was more or less a friend of the state rate setting concept". [7]

The Fall: In 1980, the first of many empirical studies began to be published that documented the lower rate of hospital expenditure growth in rate setting states as compared with non-regulated states. [8] Prior studies in the 1970s had been unable to detect significant differences. Ironically, it was also at this time that support for rate setting as a cost control tool began to diminish. Specifically, the shift can be observed with the advent of the Reagan Presidency which openly rejected rate setting as a preferred policy. More generally, it can be observed in the emerging shift of the cost containment paradigm from regulation to competition. [9] [10]

Key interest groups were active in rate setting policy, in both federal and state venues. Throughout the 1970s, the American Hospital Association (AHA) actively promoted state-based rate setting as their preferred policy option in the face of increasing federal interference in their operations. But in July, 1980, "less than one year after Congress rejected President Carter's Hospital Cost Containment Act of 1979, the AHA House of Delegates voted formally to abandon its promotion of state rate setting." [11]

Other interests did not immediately follow suit. The Health Insurance Association of America (HIAA) intensified its activities in support of the rate setting approach during this period in order to lessen cost shifting, and won legislative battles in some key states. Organized labor maintained a strong posture in favor of rate setting. And a number of private and state-based business coalitions strongly backed the regulatory approach. [12] Nonetheless, beginning in 1986, a steady stream of states have moved to deregulate their prospective reimbursement systems. Table 2.1 below lists states that have deregulated mandatory rate setting systems since 1986, along with those states still maintaining systems as of January 1, 1996:

Table 2.1: Status of State Based Hospital Rate Setting Since 1986

Deregulations Since 1986 by Year of Enactment		Continued Mandatory Regulation as of January 1, 1996
Wisconsin	1986	Maryland
Washington	1989	New York
Massachusetts	1991	West Virginia
New Jersey	1992	
Connecticut	1994	
Maine	1995	
Minnesota *	1995	

Source: Author's survey, January, 1995. * Minnesota's rate controls, enacted in 1992, were never implemented.

While some interest in forms of rate setting persisted as recently as 1994 as a regulatory option both in state and federal governments, publication of research literature on the topic has been far less frequent in recent years. With the emergence of Republican

majorities in the US Senate and House of Representatives in 1995, rate setting as a policy option has been further marginalized in favor of competitive, market oriented approaches. While a few articles have examined factors leading to rate setting's demise in one state or another, none has examined the larger trend of its passage from the center of the policy stage, nationally or in the states. No article could be identified since 1986 listing which states still maintained or had dropped such systems. No policy article before 1995 discussed the seeming incongruity of a federal government moving toward broader rate setting for Medicare via DRG's and RBRVS as the state health policy paradigm traveled in the opposite direction.

A Review of Rate Setting's Performance

Definitions and Characteristics: Hospital rate setting is defined as the establishment of rates of payment by major payers for hospital services. The American Hospital Association devised a classification system for state-based rate setting that includes four categories: 1) mandatory-regulatory; 2) mandatory-advisory; 3) voluntary-regulatory; and 4) voluntary-advisory. [13] The mandatory/voluntary dichotomy is considered the most important because of a consistent finding that voluntary systems do not demonstrate a significant difference in cost control performance from those of non-rate setting states. [14]

One difficulty in comparing studies of state-based rate setting is differences in the set of states examined by each study. This investigation will be limited to four of the six mandatory-regulatory states that have been the subject of most empirical analyses; Maryland, Massachusetts, New Jersey, and New York. (The other two states that fit this description but are not included in this study are Washington, which deregulated its system in 1989, and Connecticut, which deregulated in 1994). The criteria that distinguish these

four states are: 1) the system is run by a state agency; 2) compliance by hospitals is mandatory; 3) all major public and private payers including Medicare, Medicaid, Blue Cross, and commercial insurers are subject to regulation; and 4) the system has been in effect since 1976 or before. [15] The fourth criterion reflects the consistent finding that rate setting programs require several years of operation before they are found to have any measurable effects upon cost. [16]

A variant in state rate setting that characterizes the subject states in this study is referred to as "all payer rate setting" in which Medicare is also subject to state rules. This involvement was permitted by the 1972 and 1983 Social Security Amendments, though only Maryland, Massachusetts, New Jersey, and New York took advantage of this option. (Maryland is the only state which maintains a federal waiver permitting Medicare to participate.) Some empirical studies have confined their analyses to all-payer systems, though data comparing all-payer and partial payer systems did not produce findings of significant differences. [17]

Each state varies widely from others in its structural details; furthermore, most states have modified their systems in many substantial ways over the course of each program's life cycle. But all mandatory-regulatory systems need to face four basic challenges: 1) defining the regulated unit of payment -- principally per admission, per day, or per capita; 2) setting the base level of payment -- usually a base year; 3) varying payment rates across different classes of providers and payers; and 4) controlling the rate of expenditure growth from year to year. Also, no rate setting system has ever attempted to include outpatient hospital services within its jurisdiction -- only inpatient services. With the explosion in outpatient services growth that accelerated around 1983, this has lessened considerably the amount of total hospital revenue that is subject to state regulation. [18]

Cost Containment:

i. Per Admission/Per Discharge: The first and largest set of empirical studies on rate setting evaluated the systems on a per admission or per discharge basis. The first of these, appearing in 1980, found that between 1975 and 1978, the average rate of increase in hospital costs on rate setting states was 11.2 percent as compared with 14.3 percent in states without mandatory regulatory programs. It concluded: "Much of the initial pessimism regarding the effectiveness of hospital rate setting programs ... may be unwarranted". [19]

The largest study of rate setting, initiated by the Health Care Financing Administration, concluded in its 1986 final report that "mandatory programs saved \$36 billion dollars from 1969 to 1982 and reduced costs per discharge in states with mandatory programs 12-26 percent". [20] In the same year, the authors of the 1980 study extended their initial analysis and found that "between 1976 and 1983, states with rate setting programs have consistently had a significantly lower rate of cost inflation than states without such programs". [21]

A 1988 study, examining the performance of the four all-payer states compared with California and the rest of the nation found that between 1982 and 1986, the rate programs "reduced inflation rates by 16.3% in Massachusetts, 15.4% in Maryland, and 6.3% in New York, compared with the control hospitals in 43 states". [22]

There have been no empirical studies examining the performance of state hospital rate setting systems between 1985 and 1995. As we will see, this represents an important gap in the literature because of evidence that some regulatory systems performed far less well during this latter period.

ii. Per Capita: Critics of these findings mentioned in the previous section suggested that per admission is not the most appropriate measure because it failed to

capture other effects such as length of stay, and the shift to outpatient services. A 1987 study that used SMSAs instead of states as the unit of analysis found that SMSAs in states with mature mandatory rate setting programs between 1972 and 1982 "had, on average, 4.4 percent lower expenses per capita, 5.6 percent lower expenses per day, and 3.4 percent lower expenses per admission". [23]

A 1983 study found that state rate setting programs had lower per capita hospital expenditures of 2.0 percent per year. [24] Schramm et al reperformed their earlier per admission analysis and found in 1986 that rate setting states had 1.2 percent lower per capita expenditures between 1972 and 1984 than would have been expected in the absence of regulation. [25]

iii. *Total Health Costs*: One major criticism of the foregoing studies is that they failed to measure the impact of rate setting on total health (not just hospital) spending -- that the value of the program would be far less if it had just resulted in a shift to other forms of health spending. Finkler observed in 1987 that "the impact of rate regulation on total medical care expenditures reveals a mixed performance". [26]

At least two studies have examined this issue. One, in 1983, found that the rate of increase in Medicare Part B expenditures in states with rate setting was lower than in states without such programs, demonstrating that a hypothesized switch to outpatient physician services beyond what was happening on a national basis had not occurred. [27]

More recently, a 1991 study used a simultaneous equation model to assess the impact of rate setting on per capita hospital and non-hospital expenditures. "Mature rate setting is associated with lower per capita health care expenditures, including hospital and non-hospital ... The hypothesis that expenditures for health services in the non-hospital sector will be greater than they would have been if rate setting had not been enacted, due to unbundling, is not supported ... This is consistent with the view that hospital and non-

hospital services are complements rather than substitutes ... There is an apparent reduction in total expenses for health services associated with rate setting (about 4.3 percent)". [28] Once again, it must be noted that data for this study was all pre-1985.

Other Benefits:

i. Improvements in Access: An important feature of all mandatory rate setting programs is an explicit mechanism to reimburse hospitals for uncompensated care. No studies have examined that overall use of uncompensated care pools. However, studies from individual states have identified this feature as an important benefit. The New Jersey pool was identified as its "single most notable success". [29] The New York pool was found to have "resulted in more care provided to uninsured patients" though the program was also referred to as a "leaky bucket" that was not the most efficient mechanism to provide such services. [30]

ii. Reductions in Cost Shifting: An explicit motivation for the establishment of many state programs was to reduce cost shifting among payers, both public and private. It should not be surprising, then, that this goal appears to have been realized and documented in various studies. Rate setting states show a smaller gap between charges and costs than is observable in nonregulated states. [31] [32] [33]

iii. Improvement in Productivity: Evaluations of mandatory rate setting as early as 1982 have found evidence of improvements in hospital productivity based on payroll per day, full time equivalent employee (FTE) per day. [34] Examining hospital expenses in 43 SMSAs between 1980 and 1984, Hadley found in 1989 that "almost all of the effect of regulation on costs came from gains in the efficiency in producing hospital care and/or from reductions in the quality of care. It appears that controlling hospital payment rates gave hospitals a strong incentive to provide care at lower cost". [35] However, Anderson was unable to find a difference in the effect of rate setting programs on efficient vs.

inefficient hospitals. [36]

Negative and Side Effects:

i. Impact on Length of Stay and Admissions: Studies have found that rate setting, in some cases, has led to longer lengths of stay and higher rates of admission, an observation that will be confirmed in our review of state specific data in chapter four. "Rate regulation has brought about, in some states, an increase in hospital occupancy by increasing patients' lengths of stay". [37] Ashby found "some evidence, statistically inconclusive, that rate setting has contributed to relatively higher utilization". [38] And Sloan concluded that "one of the major shortcomings of rate setting is that it provides no incentives to reduce hospital admissions and, under certain circumstances, may even provide an incentive to increase them". [39]

ii. Impact on Quality of Care: Hadley was the first to address the potential negative effects of rate setting on quality of care as an effect related to productivity improvements. While he did not reach any conclusions, Morrissey hypothesized a similar effect in 1984 in constructing a theory of rate review on hospital operations and organization: "...the hospital product was viewed as a bundle; rate review was looked upon as a ceiling on the value of the bundle. The ceiling creates an incentive to remove elements from the bundle, i.e., to reduce 'quality'". [40]

Shortell and Hughes provided some evidence of a link between hospital mortality rates and the stringency of rate setting programs, [41] but Gaumer's results one year later directly contradicted the earlier findings. Gaumer himself found some link between the presence of rate setting and mortality following emergency inpatient admissions; this finding was contradicted by his own later research in 1989. [42] Anderson concluded that there is "some evidence that this (quality) concern may have some validity, although there are serious data concerns with these studies. [43]

iii. Impact on Diffusion of New Technology: Rate setting has also been found to slow the diffusion of services such as open heart surgery, intensive care units, and social work, as well as accelerating the phase out of redundant services such as premature nurseries. However, these results were statistically significant in only two of 15 states once other factors were incorporated in the analysis. [44]

iv. Impact on Diffusion of Competitive Health Systems: This topic is both controversial and central to the subject of this investigation. Judgments on it are included in the succeeding section on regulation and competition.

Overall Assessments/Reviews:

Throughout the 1980s, a consistent theme in empirical studies and review articles recognized the success of rate setting in the states that adopted mandatory programs. Coelen found that eight programs "have been successful in reducing expenditures per patient day, per admission, and per capita ... reducing the rate of increase by two percentage points or more per year and, in some cases, by as much as four to six points." [45] "There is substantial evidence that mandatory state reimbursement regulation is associated with a significant reduction in the rate of growth of hospital expenditures." [46] Contrasting rate setting with the managed care approach to cost control, McLaughlin concluded, "(P)repaid groups practices do not appear to be the systemwide hospital cost reducing tool that HMO supporters have hoped for, apparently taking a back seat to the regulatory approach represented by mandatory rate setting programs." [47] Zuckerman observed that "data confirm that all types of mandatory rate setting systems are effective systems of cost control." [48]

Anderson summarized ten years of research noting that "(A)ll payer rate setting is able to meet its multiple objectives of cost containment, reduction of the amount of cost shifting, improvement of access to the uninsured, and increased productivity. At the same

time, it has not stifled the diffusion of competitive health systems or new technology, and any impact on length of stay, admissions, and quality of care is small, if it exists at all." [49]

Some reviewers, though, have been careful to qualify their overall assessments with important caveats. Noting that "research literature shows conclusively that rate setting has reduced hospital expenditures," Ginsburg notes that the process of setting rates can be a very cumbersome one, and that the "prospects for competitive alternatives are reduced." [50]

Concluding the "mandatory rate setting has generally constrained hospital costs where it has been implemented," Eby cautions that "it is not clear that comparable results would be obtained (in additional states). It is still less clear that rate setting would constrain health care costs more than would increased competition and selective contracting." [51]

Paradigm Shift: From Regulation to Competition

In the voluminous literature on regulation and competition in health care, a significant subset addresses the role of state based rate setting and its impact upon the development of competitive mechanisms such as health maintenance organizations. But a curious pattern emerges as theorists describe how rate setting will harm competition and researchers detail their inability to find evidence of such harm.

Theoretical Predictions: The notion that state hospital rate regulation could interfere with market mechanisms is plausible on its face, as observed by Enthoven: "The weight of evidence, based on experience in many other industries, as well as in health care, supports the view that such regulation is likely to raise costs and retard beneficial innovation." [52]

Researchers more directly involved with rate setting analyses made similar hypotheses. Sloan notes: "With price competition eliminated by rate setting, who in the private sector will introduce innovative alternatives to the present system which offer the prospect of substantial savings in spending on hospital care?" [53] Ginsburg asserted that under rate setting, "the prospects for competitive alternatives are reduced. These alternatives, such as patient cost sharing, preferred provider organizations, and health maintenance organizations, provide incentives to reduce the volume of services as well as the price." [54]

This line of thought continued throughout the decade with analysts such as Finkler: "Some innovative cost-saving producers will be discouraged from entering medical care markets in which prices are controlled. Also, existing inefficient producers will not be encouraged to exit...thirdly, resource shifting based on regulatory incentives, and not on cost effective service delivery, will become common." [55] And Wholey: "Rate setting might decrease the ability of an HMO to respond to the market place because the regulatory process for rate setting is time consuming, imposes an administrative burden on the HMO, and may limit the HMO's flexibility in bidding for employer contracts." [56]

Evidence on Rate Setting and Managed Care: For about 20 years, researchers tried unsuccessfully to demonstrate a link between various state regulations and HMO growth and development. Goldberg found: "Legal restrictions on HMO development imposed at the state level appear to have had little effect ... HMOs respond more to impersonal market and demographic conditions than to certain legal restrictions." [57]

It is indeed difficult to conclude that rate setting and managed care are antithetical because states with mandatory rate setting generally have witnessed high HMO penetration rates. Over first noticed in 1983 that rate setting was positively related to pre-paid group practice and independent practice association (IPA) presence. [58] Anderson

made a similar observation in 1991 noting that all mandatory rates setting states except New Jersey had penetration rates substantially above the national average. [59]

This relationship does not suggest that rate setting is responsible for HMO growth, only that the two phenomena are not necessarily incompatible, and that the factors that lead a state to adopt rate setting (high per capita health costs) also create a conducive environment for HMO development, a fact noted by McLaughlin: "HMOs should flourish in areas where hospital expenses are higher." [60] Morrissey had demonstrated some years earlier that HMO market share was "determined largely by demand characteristics: search costs, income, demographics" and not by legal restrictions. [61]

Theory Revised: This apparent lack of incompatibility has led some theorists to re-examine the role of rate setting in a managed care/competitive paradigm. Schramm suggested it first: "Rate setting programs are not antithetical to competition in the hospital sector ... They are fundamentally alike ... The future is one of increased regulation and increased competition for hospitals." [62]

Ginsburg and Thorpe attempted to define the relationship: "Rate setting can be highly compatible with the most important aspects of competitive approaches, but only if it is designed to be so. The key is the degree of freedom that competitive health plans have to contract with providers ... The hospital rate setting experience in the US includes examples of both significant restrictions on competitive plans and lack of restriction. In New York, HMOs must go through rate hearings to obtain permission to pay hospitals rates that differ from those set for other payers ... Reduction of this pricing advantage in the purchase of physician and hospital services would translate into a narrowing of the premium advantage that competitive plans have over traditional plans. This would slow the growth of the latter." [63]

In spite of the demise of rate setting in most of the mandatory regulation states,

interest in the concept persisted as a policy option through 1994 -- in various national health reform proposals, in some state reform initiatives such as Minnesota's, and in academic policy proposals such as that of Rice who discussed in 1992 "the feasibility of including an all payer reimbursement system in a universal health insurance program". [64] Anderson's article title in 1991: "Down but not out" remained appropriate for rate setting at least through 1994. [65] It remains to be seen whether the concept will re-emerge in the wake of vast Congressional changes brought about in the 1994 mid-term elections.

Theoretical Frameworks

The theory of economic regulation and the punctuated equilibrium model of policy change serve as the conceptual models for this investigation. While the former is substantially older, both have deep roots in economic and political theory from a variety of sources. This section will identify these sources and place them within the context of the overall study.

Theory of Economic Regulation: Through much of political theory and world history, a dual theory of motivation prevailed that stressed both self interest and public interest in the conduct of public affairs. Augustine's The City of God divides all humankind into two "cities": "That which animates secular society (*civitas terrena*; the earthly city) is the love of self to the point of contempt for God; that which animates divine society (*civitas caelestis*; the heavenly city) is the love of God to the point of contempt for self". [66]

In American writing, this concept of dual motivation had perhaps its clearest explanation in the writings of Madison in The Federalist Papers, Number 10 and others, outlining the necessity and means to control factions under the proposed new federal constitution. "Ambition must be made to counteract ambition" to ensure that the greater

public purposes of the new federal government are attained. [67]

An important and controversial book published in 1913 provided an early challenge to the notion of dual motivation by suggesting that the framers of the new federal constitution in 1787 were largely interested in their own personal and class financial considerations in creating that document. Beard closed his study with the following conclusions: "The members of the Philadelphia Convention which drafted the Constitution were, with a few exceptions, immediately, directly, and personally interested in, and derived economic advantages from, the establishment of the new system. The Constitution was essentially an economic document based upon the concept that the fundamental private rights of property are anterior to government and morally beyond the reach of popular majorities." [68]

The first major theoretical challenge to dual motivation was made by Schumpeter in the 1930s who argued for a theory based on self interest alone. "Adversary democracy", in his view, had no place for concepts such as the common good or public interest -- voters followed their own self interests and feelings in making demands on the political system to satisfy their own needs. Elected officials, in turn, adopted policies to win votes and elections, seeking to satisfy as many and alienate as few as possible. The sum of people's preferences made up the whole without any room for a notion such as "the common good." [69]

Downs carried this analysis further in creating his economic theory of democracy and laying the intellectual foundations for rational/public choice modeling. Democratic governments, he noted, will most often favor producers over consumers in order to maximize political support because producers are more likely to reward actions favorable to their own interests. Calling his theory "political rationality from an economic point of view", he hypothesized that "parties formulate policies in order to win elections, rather

than win elections in order to formulate policy." Though Downs softened his emphasis on self interest in later years, his earlier work made that concept "the cornerstone of our analysis". [70] Buchanan, Tullock and others extended the line of reasoning to the behavior of individual voters, furthering the growing merger of microeconomics and political science: "Voters and customers are essentially the same people. Mr. Smith buys and votes; he is the same man in the supermarket and in the voting booth." [71]

The work of Schumpeter, Downs, Buchanan and others on rational theory became influential for many economists and political scientists in the 1950s and 1960s. Their theories were tested and applied in a variety of fields, one of the most fruitful being the theory and practice of government regulation. While Huntington made one of the earliest attempts to analyze regulatory behavior from a self-interest point of view in his investigation of the Interstate Commerce Commission [72], the essential "theory of economic regulation" was most clearly outlined and explained by Stigler. [73]

"The players who count in regulation," according to Stigler, "are the producers and consumers. Political intermediaries -- parties, legislators, administrators -- are not believed to be devoid of influence, but in the main, they act as agents for the primary players in the construction and administration of public policy." This shift in focus from public officials as the key actors to interest groups as the critical players was first developed by Truman in his highly noted book that pioneered the modern development of interest group theory. [74]

But Stigler went far beyond -- and contrary to -- some of Truman's central ideas in asserting that "as a rule, regulation is acquired by the industry and is designed and operated primarily for its benefit," with government regulators "captured" by the affected industry. Government has at its disposal four key means to regulate: direct subsidy, controls over entry, controls over substitutes and complements, and price fixing. "Even

the industry that has achieved entry controls will often want price controls administered by a body with coercive powers." [75]

All of the above mentioned powers can be found in operation in the health sector generally, and in the hospital sector in particular where hospitals have achieved strong entry controls through state certificate of need laws. It has already been noted in chapter one that the American Hospital Association and many of its state affiliates actively sought and promoted state rate setting in the 1970s. Certainly, the acknowledged presence of many diverse and powerful interest groups in the health sector lends familiarity to both Truman and Stigler's themes.

Stigler also notes three limitations to industries that seek regulatory protections: first, the power arrangements within the regulated industry are changed and become non-proportional to industry output; second, substantial costs can be incurred from compliance with public safeguards; and third, the industry councils are opened to potentially powerful outsiders through the public process. All of these impediments must be outweighed by the economic advantages obtained through regulation. In return, the industry "must be prepared to pay with two things a (political) party needs: voters and resources." [76]

Anticipating the growth in research on this theory, Stigler suggests that "(E)conomists should quickly establish the license to practice on the rational theory of political behavior." Many did. Hilton concluded that regulators will engage in "minimal squawk" behavior because their individual utility functions prevent them from alienating members of regulated industries. [77] Peltzman followed a similar logic in attempting to prove that regulators will choose transfers among favored industries based on a desire to maximize the regulator's personal utility curve. [78]

While economists led the way, political scientists were not far behind in applying this logic to their own behavioral models. The objectives were twofold: first, to

demonstrate that self interest was the sole and universal motivater of political behavior by public officials; and second, to characterize public officials primarily as passive agents obedient to the desires of interest groups. Early on, Latham identified this pattern, describing legislatures as "referees" who simply "ratify" and "record" the balance of power among the contending interest groups. [79]

In the 1970s, researchers found these strains in evidence in examining the United States Congress. Self-interest, namely the pervasive desire for re-election, was identified as the critical factor in explaining members' behavior. [80] [81] Even Wilson, no fan of the rational choice school, observed in 1976 the tendency for interest group needs to dominate legislative deliberations on regulation: "What was created in the name of the common good is sustained in the name of a particular interest. Bureaucratic clientelism becomes self-perpetuating, in the absence of some crisis or scandal, because a single interest group to which the program matters greatly is highly motivated and well-situated to ward off the criticism of other groups." [82]

The theory of economic regulation has been applied to the health sector, most notably by Feldstein who used regression analysis to demonstrate that self interest dominated the concerns of Congressional members in their votes for or against President Jimmy Carter's unsuccessful hospital cost containment package in 1979. [83]

In other works, Feldstein has applied the theory of economic regulation to a large number of political conflicts in the health field, finding self interest a more reliable and persistent predictor of behavior than public interest. His version regards government as little more than a market place where legislative, regulatory and other public benefits are exchanged for various forms of political support to public executives, legislators, and bureaucrats. Regulatory agencies and their policies are developed for the express purpose of monopolizing an industry, enabling an otherwise competitive set of firms to act as a

monopoly -- charging higher prices, restricting output, raising profit levels, and protecting itself from competitors. [84]

To Feldstein and others, regulation is demanded by groups -- whether doctors, hospitals, insurers, nurses, etc. -- because of the benefits it confers and is supplied by legislators and other government officials at a price. The market price that groups seeking regulation must pay is political support in the form of votes, contributions, and volunteer time. For consumers, the high information and transaction costs usually exceed the diffuse benefits of defeating regulation, explaining why industry usually wins. Deregulation is predicted to occur when political support by those regulated declines or when political support from regulatory opponents increases beyond the political benefits offered by those regulated. [85]

Other researchers have also addressed the issue of deregulation according to the theory of economic regulation. In Becker's view, political support for regulation will wither (and support for deregulation will grow) when the dead weight costs of a regulatory structure become too large to sustain. [86] MacAvoy identified these dead weight losses in the energy and transportation industries, observing that price and entry restrictions had restricted profitability so widely that production and capacity growth were severely restrained, making some regulatory change inevitable. [87]

Support for self interest as the sole explainer of political behavior grew rapidly and broadly during the 1960s and 1970s, often going to extremes. To some self interest theorists, even the most altruistic behavior only made sense when defined in self interest terms, agreeing with the judgment of Abraham Lincoln:

"...having remarked to a companion that 'all men were prompted by selfishness in doing good or evil,' and having subsequently run to rescue some trapped piglets for their mother, was asked, 'Now, Abe, where does selfishness come in on this little episode?' Lincoln answered, 'Why, bless your soul, Ed, that was the very essence of selfishness. I would have had

no peace of mind all day had I gone on and left that suffering old sow worrying over those pigs. I did it to get peace of mind, don't you see?" [88]

But after several decades of near-theoretical hegemony, support for self interest as the sole motivator of public behavior came under serious assault in the 1980s. The principal reason for the fall from grace of the theory of economic regulation, according to Meier, is simply that the capture theory had been "devastated by the empirical literature" [89]. Those attacking the theory of economic regulation and other rational choice modeling did not dismiss the importance of self interest, just its place as the *sole* or universal motivator of public behavior. "Self interest does a great job explaining the location of a new federal building in Missoula. It fails with regard to the major policy upheavals in the United States of the past decades." [90]

Cone and Dranove specifically tested the theory of economic regulation as an explainer of the adoption of hospital rate setting laws and rejected it in favor of a political choice model for three reasons: first, hospitals in rate setting states had lower prices than they would have had in the absence of rate setting; second, rate setting did not prevent hospitals from charging less than the announced rates; and third, "it is impossible to interpret the empirical evidence ... as supporting the cartel story." [91]

With regard to deregulation in the airline, trucking and telecommunications industries, Derthick and Quirk also found the theory of economic regulation unhelpful. "(T)he success of procompetitive deregulation cannot be attributed to a change in the configuration of economic interests, nor can it be interpreted as the outcome of bargaining among interest groups ... interest group regimes today derive much of their apparent power merely from the absence of challenges -- that is, from the inattentiveness of political leaders and allied forces that might launch an attack." [92] Noll reached similar conclusions in his examination of the dynamics of deregulation: "... (e)conomists have played an important role in the development of explanations of how narrow economic interests influence the political process. The difficulty is that there is ample evidence that

there is more to regulatory politics than this. The deregulation movement of the 1970s and the concomitant influence of economists in reforming regulatory politics were certainly not predictable from purely economic models of the political process.” [93]

Some pioneers of self interest/rational choice theory such as Downs and Buchanan in recent years have softened their insistence on self interest as the sole motivator of political behavior, and have moved back toward a form of dual theory. The same year that he won a Nobel prize in economics for his work in rational choice modeling, Buchanan noted that “both images (self and public interest) are partial. Each image pulls out, isolates, and accentuates a highly particularized element that is universal in all human behavior ... Each political actor, regardless of his role, combines both of these elements in his behavior pattern, along with many other elements not noted here.” [94] In faulting rational choice theory for its failure to survive “systematic empirical scrutiny”, Green and Shapiro point the way toward a more productive role for the theory to advance understanding: “The question would change from ‘Whether or not rational choice theory?’ to something more fruitful: ‘How does rationality interact with other facets of human nature and organization to produce the politics that we seek to understand?’” [95]

This investigation holds self interest as an important, though not sole, explainer of many critical facets of political behavior. As such, we seek to examine the following hypotheses in using the theory of economic regulation to explain the fate of hospital rate setting in our four subject states:

E1. Rate setting activity in the subject states should work to benefit hospitals more than consumers.

E2. Shifts in the configuration of interest groups supporting and opposing rate setting’s continuation should accompany deregulation in Massachusetts, New Jersey, and New York.

E3. Similar shifts in identifiable support should not be observable in Maryland where rate setting has not been deregulated.

E4. Elected officials should only play a secondary role in policy decisions about rate setting, with key interest groups setting the policy agenda.

E5. Identifiable shifts in overt political support from affected interest groups to key legislative leaders should be identifiable in the deregulation process.

The preceding summary of the theory of economic regulation already makes clear that some of these hypotheses will not be observable. However, it is important to this investigation to examine explicitly the activities and preferences of key interest groups and government officials. The shifting position of the American Hospital Association, for example, has already been discussed. Important to this investigation will be the position and preferences of state hospital associations and other key interest groups. By examining key interest group activity, we will learn a significant part of the answer why three states deregulated and why one state did not.

Punctuated Equilibrium Model of Policy Change: While the central dynamic in the theory of economic regulation is *interests*, the central force in the punctuated equilibrium model is *ideas*. While this latter theory is considerably more recent in development than the former, its roots also run deep in political theory.

The term, "punctuated equilibrium," actually takes its meaning from paleobiology as a means to describe the patterns and spurts in the evolutionary record over many millions of years. [96] Its first known use in the social sciences was Tushman and Romanelli's adaptation to organizational theory as a model to predict a firm's progress through "convergent periods punctuated by reorientations which demark and set bearings for the next convergent period." The convergent periods may be relatively long periods of incremental change and adaptation aimed toward increased co-alignment. Reorientation

periods are episodes of short, discontinuous change where strategies, power structures, and systems are fundamentally transformed toward a new basis of alignment." They sought a longitudinal historical perspective on organizational development because of dissatisfaction with "static, cross sectional views" that miss the impact of history and precedent on current organizational behavior. [97]

Baumgartner and Jones developed their own "punctuated equilibrium model of policy change" (without reference to Tushman and Romanelli) based on the emergence and recession of policy issues from the public agenda. They posit that new institutional structures emerge during distinct periods when new issues, ideas or "policy images" of issues/ideas emerge into broad public view. These new structures can remain in place for decades, structuring participation and establishing the illusion of equilibrium -- until new issues or images emerge to destroy the institutions, replacing them with others. [98] The midwives to these changes are commonly referred to as *policy or public entrepreneurs* who serve a role in the governmental sector parallel to that played by entrepreneurs in private markets. Schneider and Teske argue that forces for change in government can be either exogenous or endogenous, or both, but that public entrepreneurs who are embedded in public systems can help to trigger the dynamic change periods within the punctuated equilibrium framework. [99]

Embedded in Baumgartner and Jones' model are several important strands of political theory, among them: 1. the structure and scope of conflict; 2. the role of ideas in public policy making; and 3. the nature and pace of change in political systems. Each of these will be explored in turn.

1. *The Structure and Scope of Conflict in Policy Making:* A central theme in Baumgartner and Jones' model is the dynamism and potential for upheaval ever present in all policy subsystems. New policy ideas do not acquire hegemony by accident or

evolution, but rather through conflict among ideas mediated through interests espousing them. The idea of conflict as a permanent and key feature of politics was most forcefully articulated by Schattschneider: "at the root of all politics is the universal language of conflict ... politics is the socialization of conflict." [100]

An important facet of political conflict is the inability to define or limit anyone's involvement: "the distinctive quality of political conflicts is that the relationships between the players and the audience have not been defined and there is usually nothing to keep the audience from getting into the game." The self interest hypothesis that government acts only as a neutral referee of interest group conflict is absurd to Schattschneider because one can't "predict the outcome of a fight by watching its beginning because we do not even know who else is going to get into the conflict ... To treat a conflict as a mere test of the strength of private interests is to leave out the most significant factors." [101]

The critical ingredient in conflict, to Olson, is whether apathetic groups and individuals will become involved. Only the presence of "selective incentives", either positive or negative, has the ability to mobilize the apathetic; smaller, more cohesive groups will have a greater likelihood of engaging in collective activity. [102] In this study of rate setting, the size of the stakes and the relative numbers represented by each group help to explain both the strong involvement of hospitals and insurers and the weak involvement of consumers in health policy making. Of particular interest here is the process by which otherwise disinterested groups may become involved in the creation of a new policy monopoly and in the process leading to rate setting deregulation. What positive or negative incentives appeared that caused these new parties to become influential players? This is a question that is explored in the case studies.

Meier suggests one framework to understand participation in regulatory politics -- a distinct form of subsystem politics -- characterized by whether individuals or groups are

winners and losers among both regulated and non-regulated but affected groups. Changes or potential changes in these categorizations can provide a strong rationale for groups and individuals to leave the sidelines and to join in the fray. [103]

Gormley categorizes the salience of issues based upon the extent of conflict and the degree of technical complexity of the issue; an issue's salience to broad audiences will be low unless both the scope of conflict is broad and the technical complexity is low. His typology helps to explain the reasons why some groups will fail to enter a given field of conflict. In the arena of hospital rate setting, where technical complexity is extremely high, the lack of broad based public involvement in the conflict thus is made more understandable. [104]

While many factors help to influence groups and individuals to join in a conflict, changing or broadening the "scope of conflict" is an essential strategy for those seeking to upset a prevailing policy monopoly. [105] Sometimes, the scope can be broadened by creating a fresh definition to old issues, thus drawing the interest of previously apathetic parties. [106] Other times, the scope can be altered by changing the "venue" in which the conflict occurs. VanHorn et al describe six distinct venues, each with its own peculiar norms and culture, in which politics occur: boardrooms, bureaucracies, cloakrooms, chief executive offices, courtrooms, and living rooms. [107] We will see in New Jersey, for example, that the shift to the courtroom that occurred as a result of a labor union court challenge to the state's uncompensated care pool had a devastating impact on their rate setting system. In other states, shifts from the boardrooms to the legislative cloakroom have similarly had critical results.

2. *The Role of Ideas in Policy Making:* In the punctuated equilibrium model, all policy monopolies display two central characteristics: first, a definable institutional structure to shape and influence participation; and second, a powerful supporting *idea* behind

the structure. Ultimately, policy monopolies are not toppled by competing interests, but instead by the emergence of powerful new ideas that delegitimize the prevailing concept. [108] In the case of rate setting, I hypothesize that it was toppled significantly but not wholly by the emergence of the idea of managed care as an alternative means to control costs.

There is empirical support for the hypothesis that ideas matter in policy making. Derthick and Quirk's study suggests that the convergence of "elite opinion" among key leaders in Congress and the Executive Branch was the most significant factor accounting for deregulation in key three economic sectors. Leaders made significant structural change even though there was no over-powering external force driving them in this direction. As for the regulated groups: "Affected industries had only a limited ability to protect their interests through political action." [109]

Eisner stresses the role of ideas in tracking the evolution of four distinct regulatory regimes from the 1910s through the 1980s: from market regimes in the 1910s, to associational regimes in the 1930s, to societal regimes in the 1960-70s, and finally to efficiency regimes in the 1970-80s. The most recent phase is most properly characterized by the idea that "the justification of all regulatory activity must depend on that activity's economic impact as determined by cost benefit analysis. This single decision rule effectively limited the relevance of political demands." [110] Eisner's topology is useful and intriguing, and one aspect of this study examines the extent to which cost benefit analysis -- or any other economic analyses -- played a role in the deregulation decision in the subject states.

The prevailing idea -- or its policy image -- is supported and nurtured within specific political subsystems, variously referred to as policy monopolies, iron triangles, or issue networks. Heclo disputes the notion that these subsystems operate as all-powerful

iron triangles, noting numerous examples of disagreements, divisions, and overlaps among issue networks. [111] Disruption of these subsystems occurs most often through the intervention of the larger macropolitical institutions, whether legislative, executive, judicial or some combination, and not through activities within the system itself.

[112]

The "policy idea" behind state-based hospital rate setting has several components: one, that the state matters and has the ability to control health costs better than private entities; two, that health care providers are different from other producers in the economy and require other-than-normal market mechanisms to achieve operating efficiency; and three, that "because of health care's intimate nature and critical importance to people's well being, the demand for health services does not obey any of the conventional economic forces that animate markets." [113]

Goldsmith's 1984 article in Health Affairs forcefully presents the insurrectionist idea: that because of new market-oriented developments such as managed care, diagnosis related groups, employer self-funding of health plans, the Blue Cross break with hospitals, and the development of alternative delivery systems, "the economic power of providers nurtured for decades has begun to shift from those who provide care to those who pay for it." Goldsmith observes a change in the prevailing ideas, from the notion that health care can't function as a normal market, to the belief that health care can do so if effectively reorganized. [114] For the punctuated equilibrium theory, the challenge is to demonstrate that the changed idea -- valid or not -- translated into policy action in the three deregulated states, and conversely, that its impact did not affect the other study state.

3. *The Nature and Pace of Change in Political Systems*: One repeated theme in much political science literature is the incremental pace of change in political systems.

Van Horn et al observe that "a key feature of the American political system is the slow pace of change. Our political institutions were designed to inhibit change, not to facilitate it." [115] Lindblom, terming the phenomenon as "muddling through," observes that "incrementalism can be the result of deliberate steps to make limited reversible changes in status quo because of bounds on the ability of decision makers to predict the impact of their decisions." [116] Wildavsky makes the same essential point in examining the process of public budgeting, noting that new budgets for agencies are most commonly based on the previous year's allocation. [117]

Riker, however, makes the opposite observation that "disequilibrium, or the potential that the status quo be upset is the characteristic feature of politics" and can occur anytime that political actors can introduce new dimensions of conflict, destabilizing a previously stable situation. [118] Through the punctuated equilibrium model, Baumgartner and Jones synthesize the two perspectives into one framework. Policy subsystems can remain in a seemingly stable environment for years or decades, only to be upset when new players upset the stability through the introduction of a new idea and an accompanying new policy image.

We can observe quite easily that the mandatory rate setting systems held this characteristic. Most were in effect for about two decades or longer. During that period, the rate setting subsystems were hardly stable, and evolved continuously through negative feedback. Through this study, we will examine the nature of that stability, and the apparent suddenness with which each system was toppled. We will also seek answers to why the system in Maryland remains; under the punctuated equilibrium framework, the Maryland system would seem to be accident waiting to happen.

In looking at state rate setting in the context of punctuated equilibrium, we expect to examine the following hypotheses to explain its fate in six states:

P1. In each deregulated state, there should be an identifiable "policy idea" that emerged to accompany rate setting's demise.

P2. In Maryland, we should be able to observe the non-emergence of the new policy idea, or else clear indications of non-acceptance that differ from the deregulated states.

P3. In deregulated states, we should observe altered institutional structures to account for the demise of rate setting and the ascension of the new policy idea.

P4. In Maryland, we should observe no indication of major institutional change.

P5. In deregulated states, we should observe the emergence of new players (groups or individuals) who, by broadening the scope of conflict, were able to undermine the rate setting policy monopoly.

P6. In Maryland, we should observe either no such new players, or clear indications as to their ineffectiveness.

The next chapter outlines the methodology by which we examine the validity of both sets of hypotheses, economic and political. In summary, by using these two rival theories, we are asking whether changes in interests or in ideas were more important in explaining a significant transformation in state level health policy. In the past, the questions posed by Schumpeter, Downs, Stigler, Feldstein and other self interest/rational choice theorists compared self interest to a pure public interest model. But public interest as a theory is overly simplistic, and to some extent a straw man easily toppled by any more robust rival theory. The self interest model deserves a more substantive and compelling rival theory to demonstrate its real value as a model of public behavior, a rival more complex and cognizant of the many layers of thought, behavior and culture that make up the political behavior of all interested players.

Do legislators and other policy makers chiefly follow ideas or interests? Are concentrated interests concerned with profit and revenue maximization only, or do they, too, respond to changes in relevant policy ideas? Can we observe the construction and subsequent destruction of policy monopolies as a prelude to significant policy change. Our data collection and subsequent analysis will attempt to provide answers to these questions.

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CHAPTER III

RESEARCH METHODOLOGY

The methodological choice for this investigation of the fate of hospital rate setting in four states is the case study, as opposed to experimental or quasi-experimental research. This option was selected because of the nature of the particular regulatory phenomenon under study.

Yin has done much to provide structure and rigor to the case study method in his two volumes on the topic. This investigation relies heavily upon his proposed structure. He specifies three criteria necessary to justify use of the case study option: 1) when the study "copes with the technically distinctive situation in which there will be many more variables of interest than data points;" 2) when the study "relies on multiple sources of evidence, with data needing to converge in a triangulating fashion;" and 3) when the study "benefits from the prior development of theoretical propositions to guide data collection and analysis." [1] [2]

This investigation satisfies all three of Yin's requirements. First, there are many contextual variables that help to explain the demise of rate setting in three states and its continuation in one other, certainly far more than the data points represented by the four subject states. These variables fall into numerous domains, including demographic, political, cultural and economic characteristics, health and hospital market structure, organizational factors, state leadership variables, and much more than can be captured in a purely empirical study.

Second, this study required several sources of evidence -- as will be discussed shortly -- including interviews with key participants in the political process, archival records, documentation, journalistic accounts, and other sources. No single data source could provide adequate information to evaluate the reasons for rate setting's fate, and so data and information were sought from a multitude of sources. Triangulation requires that at least three sources converge to provide confidence in any final conclusions relative to the proposed hypotheses.

Third, the case study is designed as a means to test theoretical propositions, not to generalize from a data set to a population. In this investigation, the fate of rate setting in four states was examined principally to explore the validity of two rival theories -- one political and one economic. In the process, we learn not just about the phenomenon of state rate setting, but also about the two theories.

This chapter will: first, define more clearly the theoretical propositions under study; second, specify the case study model and research design for the investigation; third, identify the data sources and collection procedures; fourth, outline the analysis strategy; fifth, present means to maximize validity and reliability; and sixth, note some special issues relating to the writing of this final report.

Theoretical Propositions

In designing a case study investigation, we consciously attempt to organize a research methodology according to some theoretical relationship to relevant literature, policy issues, or other sources. While theory is important in helping to understand and to explain the outcomes of particular cases, the cases also help to test the application of theory in specific situations. If the cases do not conform to the theoretical model, then modification of the theory may be required. This is consistent with the basic definition of

the case study as inquiry designed to test theory, and not to generalize about a data set to a larger population.

Particular emphasis in case study research has been placed on the use of rival theories as a means to focus data collection on the most important features of a case. Results of case study analysis are more robust if data from individual cases are demonstrated to support the same theory and do not provide support for an equally plausible rival. Data from each case can be examined to determine which theoretical pattern is more valid. Alison demonstrated the strength of this approach in his use of three “theoretical lenses” to examine the Cuban Missile Crisis of 1962. While most policy analysis in that period used an implicit rational policy approach, Alison also used an organizational process model and a bureaucratic politics model to show that different models can produce vastly different understanding of the same case. [3]

The central question of this study is: Why was mandatory hospital rate setting discontinued in Massachusetts and New Jersey, why is it likely to be deregulated in 1996 in New York, and why is it continued in Maryland? The rival theories that are used to interpret the results of this study are the theory of economic regulation and the punctuated equilibrium model of policy change.

Chapter two outlines a series of hypotheses that should be supported if the theory of economic regulation applies. These hypotheses are:

E1. The conduct of rate setting activity in the subject states should have resulted in more benefits for hospitals than for hospital consumers.

E2. Deregulation should have occurred in Massachusetts, New Jersey and New York because of a shift in the configuration of interest groups supporting and opposing its continuation.

E3. The shifts identifiable in those four states should not be observable to the

same degree in Maryland.

E4. Elected officials should have played only a secondary role in moving the deregulation agenda — with affected interest groups leading the way.

E5. Some identifiable shifts in overt political support from affected groups to key legislative leaders should be identifiable in those states that deregulated.

Chapter two also outlines a series of hypotheses that should be demonstrated if the punctuated equilibrium model is applicable. These hypotheses are:

P1. In each deregulated state, there should be an identifiable "policy idea" that emerged to accompany rate setting's demise.

P2. In Maryland, we should be able to observe the non-emergence of the new policy idea, or else clear indications of non-acceptance that differ from the deregulated states.

P3. In deregulated states, we should observe altered institutional structures to account for the demise of rate setting and the ascension of the new policy idea.

P4. In the non-deregulated state of Maryland, we should observe no indication of major institutional change.

P5. In deregulated states, we should observe the emergence of new players (groups or individuals) who, by broadening the scope of conflict, were able to undermine the rate setting policy monopoly.

P6. In Maryland, we should observe either no such new players, or clear indications as to their ineffectiveness.

To analyze these propositions in light of the data and information collected through the case study process, the following chart is used as the key methodological tool:

Table 3.1: Predicted Hypotheses

	MD	MA	NJ	NY	Overall
E1. Rate Setting should benefit hospitals more than consumers.					
E2. Shifts in the configuration of interest groups supporting rate setting should accompany deregulation.	-				
E3. Shifts in interest group support should not be observable in Maryland.		-	-	-	
E4. Elected officials should play only a secondary role, with interest groups leading the agenda.			-		
E5. Identifiable shifts in overt political support from interest groups to key legislative leaders should be identifiable.					
P1. An identifiable "policy idea" should accompany deregulation.	-				
P2. In Maryland, we should not observe the emergence of a new policy idea, or else have clear indications of non-acceptance.		-	-	-	
P3. In deregulated states, we should observe altered institutional structures to account for the demise of the old idea and the ascension of the new one.	-				
P4. In Maryland, we should observe no similar institutional change.		-	-	-	
P5. In deregulated states, we should observe the emergence of new players who, by broadening the scope of conflict, undermined the rate setting policy monopoly.	-				
P6. In Maryland, we should observe either no such new players, or clear indications as to their ineffectiveness.		-	-	-	

In essence, the case study exploration is conducted for the purpose of collecting verifiable and valid information to complete this chart. The chart tracks changes in institutional structure, prevailing policy ideas, and key players (both interest groups and public officials). The completed chart provides the information necessary to evaluate the overall applicability of each of the rival theories to the specific developments in the four subject states.

Obviously, Maryland is separated from the other three states because mandatory rate setting is secure for the current time period, and the relevant questions are different.

As opposed to comparing pre and post deregulation time periods, in Maryland, we compare the long-standing structures and ideas associated with their rate setting model with current thinking (circa 1995). This provides some information to answer the question of whether Maryland is different from the other three states, or just an example of another future deregulation waiting to happen.

Though New York is not yet deregulated as of the writing of the final report, its deregulation is widely predicted and expected, and developments in that state since the fall of 1994 fit into the pattern observed in Massachusetts and New Jersey during their deregulation processes. To include New York with Maryland at this time would distort the results of the study in serious ways. As such, New York is treated as one of the deregulated states in this study.

Hypotheses E1 through E5 refer to the economic model, the theory of economic regulation. Hypotheses P1 through P6 refer to the political model, the punctuated equilibrium model of policy change.

Research Design/Model Specification:

Yin identifies six distinct types of case studies based on two sets of choices. The first set of choices involves single or multiple cases. This investigation uses the multiple case strategy, looking at four current or previous mandatory rate setting states. The criteria involved in selecting these four were outlined in chapter one. The second set of choices involves the type of case study: exploratory, descriptive, or explanatory/causal. The explanatory/causal study presents data to determine cause and effect relationships. This option is closest to the objective of this investigation, to determine the cause of rate setting's disposition in the four subject states. Thus, the basic design of this investigation is the multiple, explanatory case study. [4]

Five components need to be specified for a full research design. Though some of these have already been discussed, they are presented below for summary purposes:

1. *Study Question*: Why was mandatory hospital rate setting discontinued in Massachusetts and New Jersey, why is it likely to be discontinued in New York in 1996, and why has it continued in Maryland?

2. *Study Propositions*: Did the demise of rate setting in three states (and its parallel continuation in one other) occur because of self-interest activities on the part of affected institutions, interests and legislators as explained by the theory of economic regulation? Or did the fate of rate setting happen because of changes in the prevailing policy ideas promulgated by leading groups and individuals as explained by the punctuated equilibrium model of policy change?

3. *Unit of Analysis*: The unit of analysis for the investigation is the state hospital rate setting program within each of the four states. The unit of analysis is not: the legislature, the hospital industry or market, the state itself, nor any other entity. The study does not include any embedded units of analysis. The study likewise is not concerned with the effects of deregulation, nor with the merits of either policy option.

4. *Linkage of Data with Propositions*: The technique used to analyze the data involves chiefly pattern matching. This and the next topic will be explored in more detail in the "Analysis Strategy" section of this chapter. Briefly, the data from each state's activity are compared to developments in the other states and to the predicted pattern of the two rival theories.

5. *Criteria for Interpreting Findings*: The key analysis criteria for this study is triangulation, the requirement that all conclusions relative to acceptance or dismissal of the theoretical hypotheses must be verified by at least three independent sources. In conducting the analysis and interpreting the findings, we draw on all relevant evidence,

include all major rival interpretations, focus on the critical aspects of the case study, and draw on the investigator's own prior knowledge and experience in this subject area.

Data Sources and Collection Protocol:

The principal sources of evidence for the investigation include the following:

Interviews: In each of the four states, it was necessary to identify and interview at least 15 knowledgeable health policy leaders. At least one key source from each of the following institutional settings was interviewed: hospitals, Blue Cross, commercial insurance, health maintenance organization, business, labor, legislature, and executive branch. In some cases, it was necessary to interview more than one individual from each setting because of divergent views within that sector. For example, interests vary widely among hospitals depending upon teaching, community, rural, and disproportionate share status. Subjects were identified as individuals who were active participants within their institutional base during the period when the decision to deregulate was made; thus, for example, it was more important to identify a Massachusetts official who served in the Legislature in 1991 rather than someone currently serving. In Maryland, the emphasis was on officials who served during the period 1989 to 1995 when no such decision to deregulate was made.

Each participant was interviewed for between 30 and 60 minutes in his or her home state (with one exception). Interviewees were notified ahead of time concerning the purpose and scope of the interview. The interviews were semi-structured, with common questions asked of each subject, but also designed to draw out finer details of each state's actions. All interviews were tape recorded. Subjects were provided with a transcript of their remarks for their review and correction. The appendices to this study include: a list of all interview subjects and their positions during the deregulation process, the basic

questionnaire used in all four states, and matrices outlining the responses from each interview subject to the basic questions.

2. *Documentation*: Key sources include: written reports, analyses and research studies of each state's rate setting program; administrative documents; newspaper reports; review of files of relevant organizations, where appropriate; letters; memoranda; lobbying alerts; meeting agenda; proposals; and other similar sources.

3. *Archival Records*: Included were statutes, regulations, organizational charts, budget documents, survey data, lists of names, and other similar sources.

4. *Direct Observation*: This option was not available in the two already deregulated states of Massachusetts and New Jersey; but it was employed to a limited extent in the two states, Maryland and New York, that maintain rate setting regulatory systems.

The particular focus of the study is the decision to deregulate in three states, and the decision (or non-decision) not to do so in Maryland. The critical time period is the immediate years leading up to rate setting deregulation and the actual decision process period. However, this process can not be fully separated from the circumstances and the political and economic context that led to regulation in the first place nor from the conduct of the regulatory system.

Regarding the order of the conduct of the study, Massachusetts was used as a pilot study in the winter of 1994/95 because of its easy proximity. Most interviews and data collection in New Jersey were conducted in April, 1995. Similar activity in Maryland was conducted in June, 1995. New York interviews and activities were conducted during the months of June and July, 1995. At least one visit to each of the three non-residential subject states was conducted by the author.

Analysis Strategy

The general approach of the analysis is "analytic generalization" as opposed to the more familiar method of statistical generalization, in which inferences are made about a population on the basis of empirical evidence from a data sample. As Yin describes, in analytic generalization "previously developed theory is used as a template with which to compare the empirical results of the case study. If two or more cases are shown to support the same theory, replication may be claimed". [5] This distinction reinforces the special role of the case study, in which generalization of results is made not to populations but to previously developed theoretical propositions.

Among the predominant and available analytic techniques (pattern matching, explanation building, time series analysis, and program logic), this investigation employs pattern matching. This approach compares an empirical pattern with the predicted pattern from each rival theory. Internal validity is strengthened when the resulting patterns are shown to coincide.

In the context of this study, we seek to determine whether the suspension or continuation of rate setting in each state was due primarily to the actions of interest groups or to changes in the predominant policy ideas at work in each state. This approach requires inquiry into the policy processes within each organization as well as their public and private political actions. We seek to identify similarities and differences within each of the four states and make use of matrices, flow charts, chronologies, and other techniques to tease out and examine various patterns. For example, in each of the deregulated states, some triggering event is identified early in the policy process; on a simple matrix, we will identify the nature of the event, the actor involved, and the immediate results.

As previously mentioned, triangulation is used as an important analytic technique

as we seek confirmation from at least three separate sources for all theoretical hypotheses. With the ample number of sources being identified in each state, we look to exceed that number in most cases.

With regard to the case histories of each state, we provide descriptions and analysis of the process in each of the four states in detail in chapter four. However, the principal part of the study involves cross-state analysis to describe and explain both the activities and the patterns involved in each state's process; the results of this analysis are detailed in chapters five and six..

Validity and Reliability

To enhance overall reliability and validity, a formal case study database was constructed that includes questionnaires, organized interview notes, field notes, archival documents, and all other materials associated with the study. This final report contains all relevant evidence and data.

1. *Internal Validity*: The pattern matching technique in the data analysis phase is designed to enhance the internal validity of the investigation. By internal validity, we mean the extent to which true causal relationships regarding the fate of rate setting in each state can be determined. When patterns are determined to coincide in a clear, logical and consistent fashion, the internal validity of the conclusions is strengthened, and the possibility of identifying spurious relationships is reduced.

2. *Construct Validity*: Construct validity -- meaning the use of appropriate operational measures for the concepts under study -- is established by using multiple sources of evidence from each state, and by establishing a chain of evidence leading to each conclusion. Construct validity is enhanced by being as clear as possible concerning the phenomenon under study; with rate setting programs, that clarity is evident.

3. *External Validity*: This area is the weakest part of the study and a problem for most rate setting literature. Even though rate setting has been shown to be effective in certain states, there is no clear evidence that the results would be applicable to other states during any given period of time. [6] If generalizability is to be established in this investigation, it is more germane to the relevance of the rival theories than to any larger conclusions about the value of mandatory hospital rate setting.

There are other states that established mandatory programs in the 1970s and 1980s, (Connecticut, Washington, Maine and West Virginia), and others that have considered its establishment or may do so in the future. To the extent that the application of one or the other rival theory is replicated in the four states, the results could be generalized to other states undertaking similar or related programs in the future, though not strongly. Most importantly, results may be useful in clarifying the strengths and weaknesses of the two rival theories.

4. *Reliability*: This test is meant to ensure that future investigators, following the same pattern, would reach similar conclusions. The primary means to ensure reliability is the development of a clear case study protocol, and the creation of a case study data base. As many steps as possible will be operationalized and documented.

Final Report

This final report describes the theoretical and methodological issues involved in this investigation. The form of this final report assumes the comparative case study form (similar to that employed by Allison in examining the Cuban Missile Crisis) in which facts and data are repeated separately in the context of each rival theory [3] rather than the linear-analytic framework (similar to that of most policy journals). The chosen technique helps to show more precisely how each case fits with the relevant theory. Thus, chapter

four presents the overall history and development of the four rate setting programs; chapter five examines the programs in the context of interest group competition and the theory of economic regulation; chapter six examines the rate setting programs from the perspective of the punctuated equilibrium model.

Notes to Chapter III

[1] Yin, R.K., *Case Study Research: Design and Methods*. Third ed. Applied Social Research Methods Series, Volume 5. Vol. Volume 5. 1994, Newbury Park, CA: SAGE Publication.

[2] Yin, R.K., *Applications of Case Study Research*. Applied Social Research Methods Series, Vol. 34. 1993, Newbury Park, CA: SAGE Publications.

[3] Allison, G., *Conceptual Models and the Cuban Missile Crisis*. American Political Science Review, 1969. 63(September): p. 689-718.

[4] Yin, 1994, chap. 2.

[5] *ibid*.

[6] Sloan, F., *Rate Regulation for Hospital Cost Control: Evidence From the Last Decade*. Milbank Memorial Fund Quarterly, 1983(61): p. 195-217.

CHAPTER IV

THE BACKGROUND AND CONTEXT OF THE STATES

“When I sat down and tried to learn the system, it took an awful lot of effort. Once I did, I thought, ‘how could a group of people all over 21 have agreed to play by these rules?’”ⁱ

The development of mandatory hospital rate setting in the four subject states was not accidental. It emerged in its fullest and most distinctive form in Maryland, Massachusetts, New Jersey and New York as a result of a complex mix of economic, political, cultural, and organizational factors that evolved over long periods of time. All of those same factors are also important in understanding the ultimate fate of rate setting in these jurisdictions.

The four states under analysis in this study resemble each other in many important features, and also differ in critical ways that help to explain the varied genesis, maturation, and disposition of rate setting in each state. This chapter sets the stage for the analysis of interest groups that follows in chapter five and the analysis of policy ideas pursued in chapter six by identifying the context and development of rate setting in the subject states. First, prior research that identifies some predictors of why hospital rate setting was established in the various states is discussed. Next, a review of existing data sources will present critical economic background and other features in the subject states. Finally, the evolution of mandatory rate setting in the four states will be presented in thematic form.

ⁱ Interview with Robert Hughes: Mass. Assn. of HMOs, Boston, 12/15/94.

Prior Research on Rate Setting in the Subject States

The development of mandatory rate setting in the four subject states was not a random phenomenon. While more than 30 states adopted some form of rate setting or budget controls on hospitals during the 1960s and 1970s, only a smaller group opted to establish mandatory state controls on hospitals and private payers. [1] Of those, only four chose to establish long term mandatory prospective charge controls on all public and private payers for health services.

As discussed in chapter two, prior research has attempted to identify empirically the variables that led some states to adopt rate setting programs while others did not. The small number of states involved in mandatory rate setting has limited the validity and usefulness of these studies. Sloan identified the following factors as potential indicators for adoption of mandatory rate setting: higher than average personal per capita income, higher than average population density, higher than average physician to population ratio, higher than average hospital bed to population ratio, and higher than average market shares for Blue Cross and Medicaid. [2]

Fanara used the concept of capture which is embedded in the theory of economic regulation and concluded that both public and private payers sought rate setting in order to control their own health care expenditures. In the traditional 'capture' model, the regulated industry, in this case the hospitals, does the capturing; Fanara adapts that framework by focusing instead on the interests of payers. The three significant predictors identified in his study include a high rate of change in hospital costs in the two years prior to enactment, a high percent of a state's budget spent on Medicaid, and a high percent of for-profit hospital beds in the state. In contrast to Sloan, he found that Blue Cross market share was not a significant predictor for rate setting's adoption. [3]

Cone and Dranove rejected Fanara's inclusion of the hospital variables, finding them non-significant when Medicaid expenditures were included, and also found that Blue

Cross market share was not a significant predictor. They determined that “liberal states with budget deficits and large Medicaid expenses were most likely to enact rate setting laws.” [4]

Cone and Dranove also tested the theory of economic regulation to explain the initial passage of rate setting laws, but rejected its applicability for three reasons: first, hospitals in rate setting states had lower prices than they would have had in the absence of rate setting; second, because rate setting did not prevent hospitals from charging less than the announced rates, the hospitals that did so could expect to attract price responsive patients; and third, “it is impossible to interpret the empirical evidence ... as supporting the cartel story.” They conclude that rate setting reduced the inefficiencies that had been created by the open-ended federal Medicaid program. [5]

A limitation of this research, and indeed research on rate setting in general, is that data are limited to the pre-1985 period. As this study will show, rate setting’s performance in holding down the rate of growth in hospital costs appears to have deteriorated markedly in the 1985-1995 decade, particularly in comparison with its performance during the pre-1985 period. The pre-1985 performance led some researchers to make erroneous predictions about rate setting’s future prospects. Cone and Dranove, for example, conclude their study by suggesting, “we would not be surprised to see nationwide comprehensive rate setting for all privately insured fee for service patients before the end of the decade.” As we know, their prediction did not come to pass.

A major difficulty with empirical research on state hospital rate setting was its inability to account for a host of non-quantitative variables that help to explain the program’s ups and downs in the various states. Sloan discusses this problem in the following helpful way, making his own offhand prediction about rate setting’s future that has proven remarkably to the point:

“Most studies of rate setting by economists have specified rate regulation as an exogenous variable. This is understandable for the following reasons.

To assess why such programs have been implemented in some areas and not in others as well as why the implemented programs differ would require in-depth knowledge of legislative and bureaucratic politics. Outcomes of rate setting will ultimately depend on political decisions as well as those of hospitals and doctors. In fact, one plausible view of the future of rate setting is that the present emphasis on cost containment will eventually evolve into one of hospital protection in which the rate-setting agency serves the interest of a local hospital cartel. With control over entry and budgets of individual hospitals, such regulation can guarantee a monopoly price to the cartel while insuring that each of the existing producers obtains a specific market share... Future research on rate setting should delve into the interplay of forces affecting regulatory legislation." [6]

As we will see, the rate setting programs in at least three of the subject states did shift from an emphasis on cost control to one more concerned with hospital financial stability. Sloan's suggestion for an examination of the interplay of forces affecting these systems is, in fact, the basis of this study.

Eby and Cohodes followed a similar line of thinking in their review of the extensive literature on rate setting's effectiveness. Their overall assessment of rate setting's performance in 1985 was clear and familiar: "the verdict is unanimous: no matter how cost is measured, every study in this group found that mature rate-setting programs, taken together, constrained hospital costs; and all but one of these findings were statistically significant." However, this successful record did not leave them sanguine in assessing rate setting's future prospects:

"...the states that have tried rate-setting are not representative of the entire country, much less the remaining unregulated states. Most are in the Northeast corridor. They continue to be among the states with the highest hospital costs in the country. Compared to the West and Midwest, they reflect a greater willingness to apply regulatory solutions to social problems...

"Circumstances change over time, as well as from place to place... the inevitable change in political style and will that accompanies changing state administrations is hard to capture in complex statistical analysis, yet it may be of great importance...

"The impact of rate regulation on various interests depends on how it is implemented and on local circumstances. Rate-setting systems are not

the same everywhere, and need not be the same in the future as they have been in the past ... the effects of rate setting reflect the motivation (as well as the resolve) of the rate-setting authority. If there are widespread changes in states' priorities, then the performance of new rate-setting programs will differ correspondingly from past performance." [7]

Both Sloan's and Eby & Cohodes' predictions have proven remarkably accurate in light of the ultimate direction and disposition of rate setting in the various states. In the case of rate setting, the past (as measured up until the mid-1980s) proved a very poor indicator indeed of the system's future performance.

Characteristics of the Subject States

While the major thrust of this chapter examines individual case histories in the subject states, a number of demographic, health system, and political characteristics are important to present and evaluate prior to examining the individual stories of rate setting. The indicators included in this section were chosen because they were mentioned in prior research on state hospital rate setting, or else because they have become important in the development of these systems in the 1990s, particularly the growth in HMO penetration rates. Data include numbers for the particular states as well as US averages. Categories chosen are organized as follows:

A. Per capita personal income

B. Health and Hospital Expenditures

1. Health expenses per capita
2. Hospital expenses per capita
3. Average annual percent change in per capita hospital expenditures
4. Hospital expenses per admission
5. Medicaid expenditures as percent of total state budget

C. Other Health system Characteristics

1. Hospital admissions per 1000 population
2. Hospital beds per 1000 population
3. Average inpatient days per admission
4. Occupancy rates in community hospitals
5. Non-federal physicians per 1000 population
6. Health sector employment as percent of total employment
7. Non elderly uninsured as percent of total population
8. HMO Penetration
9. Tax Status of Hospitals

D. Political Characteristics

1. Political Culture Categories
2. Political Innovation Scores

In general, the data will show introduce several important points and themes that will appear throughout the study. All four states currently have high levels of personal income and high levels of overall health care expenditures; this represents a change only for New Jersey which had much lower levels of health spending before 1982.

Massachusetts, Maryland and New York all began their regulatory periods with high hospital costs (per admission and per capita), but while hospital costs stayed high in Massachusetts and New York during their rate setting years, they declined in Maryland, and increased substantially in New Jersey. In all states except Maryland, there was a significant deterioration in rate setting's cost control performance after 1985. The data also show that the rate of hospital admissions increased during the rate setting years, and lengths of stay dropped more slowly than the rest of the nation. Medicaid spending is consistently higher than the national average in all four states, but varies depending upon the measure used.

Regarding other important health system variables, all four states have levels of uninsurance that are below the national average, though their performance compared with

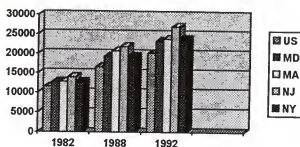
others states has declined in recent years. HMO membership grew faster than the national rate in all states except New Jersey during the rate setting years. All acute care hospitals in all four states were not-for-profit during the rate setting years, and before. All four states have a high ratio of physicians to population, but not unusually high physician costs. Regarding political characteristics, all four states score highly in indices for innovation in establishing new laws and programs. This is consistent with their image as liberal, urban, and high social spending states.

In summary, the data preview important themes that will emerge in the case studies. First, Maryland stands out in showing a better than average cost control performance during the rate setting years. Second, New Jersey stands out in showing a much worse performance during these same years. Third, Massachusetts and New York always have, and still do, stand out for very high levels of health and hospital spending. These differences emerge despite some striking similarities: all four hospital sectors are non-for-profit, and all four states are historically liberal, innovative, urbanized and high in levels of social spending. Strong HMO growth in Maryland, Massachusetts and New York led to very different consequences in determining the fate of rate setting. (All dollar figures shown are nominal.)

A. Personal Income Per Capita: One strong consistency among the four subject states is their relatively high per capita income levels over time. The table and chart presented on the next page show that each of the four states has been among the seven highest states in personal per capita income since the early 1980s:

Table 4.1: Per Capita Income

	1982	Rank	1988	Rank	1992	Rank
US	11,481		16,644		20,114	
MD	12,736	6	19,314	5	23,249	5
MA	12,751	5	20,701	3	23,811	4
NJ	13,966	3	21,822	2	26,969	2
NY	12,703	7	19,299	6	23,842	3

Chart 4.1: Per Capita Income

Sources: 1982 & 1988, Survey of Current Business, April, 1989; 1992, Survey of Current Business, July, 1993.

This pattern of high income is important, among other reasons, because personal income has been identified as a significant predictor of state differences in health care spending. The General Accounting Office concluded that differences in personal income may account for as much as half of the difference in health spending rates among the various states. Some reasons suggested for this association are that higher paying jobs typically include more generous health coverage, that higher income persons are more able to afford out-of-pocket health-related expenditures, and also that higher personal incomes will translate into higher wages for health care sector personnel. [8]

The per capita income variable becomes important to consider in evaluating the relative burden faced by the various states in meeting their health care needs. While our subject states are among the most expensive states on a variety of unadjusted health spending measures, when health care spending is considered as a percentage of average

family income, their relative ranking among the states is more mixed: New York ranks 11th highest, Massachusetts is 28th highest, Maryland is 36th highest, and New Jersey is only 48th highest. These figures show why data on ability to pay are as important to evaluate as data on other aggregate spending categories. [9]

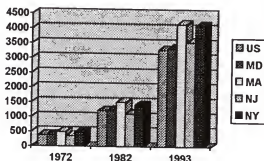
B. Health and Hospital Expenditure Categories:

B.1. Per Capita Health Care Payments: Unlike per capita income, the four states' performance on per capita health care costs is more varied:

Table 4.2: Per Capita Health Payments

	1972	Rank	1982	Rank	1993	Rank
US	381		1220		3285	
MD	390	10	1232	14	3343	12
MA	489	1	1508	1	4157	1
NJ	355	27	1115	26	3551	5
NY	488	2	1417	3	4111	2

Chart 4.2: Per Capita Health Payments



Source: Figures are in nominal dollars. 1972-1982, *Health Care Financing Review*, summer, 1985; 1993, *Health Care State Rankings*, Morgan Quinto Press.

These data present a number of interesting observations. First, Massachusetts and New York retain their position of having very high levels of per capita health spending in spite of the existence of mandatory rate setting during most of the 21 year period in question. While it is true that rate setting only attempted to control inpatient hospital spending, it seems clear that these programs did little to change the relative position of

these two states in this broader health spending measure. Regarding Maryland, we shall see in subsequent data a dramatic drop in that state's rates with regard to hospital spending; however, this data indicate that their success in controlling hospital spending rates, which is widely known and quoted by state health policy makers and rate setting supporters, did not translate into a similar drop in this category. Maryland's performance on this measure raises the question of whether their successful hospital cost control program has disproportionately shifted costs to other health care settings.

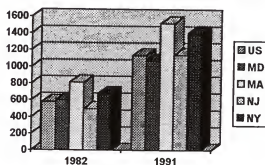
The New Jersey case is perhaps the most noteworthy here. From a per capita spending position below the national average in 1972 and 1982, the state jumped to fifth among the 50 states in 1993. As we shall see, the New Jersey rate setting program, the prototype for Medicare's Prospective Payment System, lost much of its capacity to control costs in its latter years, and appears to be associated with a sizable increase in health and hospital spending in the state during the 1980s.

Defenders of rate setting programs do not like per capita health data used in evaluating their systems, chiefly because non-hospital costs are not a target of rate setting regulators. While these data should be included in any evaluation of rate setting's performance, they should not be used alone. Weaknesses in this measure as an evaluative tool include its inability to account for shifts in the numbers of individuals who are insured or uninsured -- because uninsured persons use fewer health services, it can be expected that states with greater than average increases in medical indigency will show lower rates of growth. Also, increases in this measure may reflect excessive increases in costs not associated with inpatient prospective rate setting regulation, such as physician, home health, prescription drug, nursing home, or other services.

B.2. Per Capita Hospital Payments: This measure shows a trend similar to per capita health spending, with one important exception:

Table 4.3: Per Capita Hospital Payments

	1982	Rank	1991	Rank
US	577		1134	
MD	606	11	1072	24
MA	810	1	1517	1
NJ	498	30	1138	16
NY	679	3	1404	2

Chart 4.3: Per Capita Hospital Payments

Source: 1982, 1991 HCFA, Office of the Actuary

The trends for Massachusetts and New York (high expenditures then and now) are similar, whether the category is per capita health or per capita hospital spending; similarly, New Jersey's figures demonstrate a clear direction under rate setting toward greater hospital spending as compared with other states. Maryland, however, shows a different pattern toward a lower rate of per capita hospital spending among the 50 states. This pattern is consistent with data showing per admission rates of spending that indicate a lowered rates of hospital spending under Maryland rate setting. It is a distinct difference from the other three subject states, and an indicator that Maryland policy makers point to with satisfaction when defending their choice to retain rate setting.

B.3. Average Annual Percent Change in Per Capita Hospital Expenditures:

1980-1991: The data on rate setting's performance, however, were not completely consistent, a reality the perplexed policy makers and affected their decisions in evaluating

rate setting programs. The following chart makes clear that both supporters and detractors of rate setting could find their own sources of comfort and support:

Table 4.4: Annual Change in per Capita Hospital Costs: 1980-91

	Annual % Change	Rank
US	8.9	
MD	7.6	47
MA	8.3	42
NJ	10.7	5
NY	9.0	33

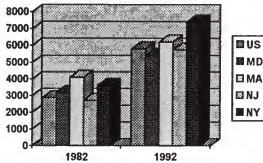
Source: "Health Spending by State: New Estimates for Policy making," *Health Affairs*, Fall, 1993. Data source: HCFA.

This chart must be examined in tandem with Table 4.3. Throughout the decade of the 1980s, policy makers in Massachusetts and New York trumpeted their rate of growth relative to other states as a signal achievement and a key justification for the continuation of their rate setting programs. But the Massachusetts data principally seem to suggest that its original spending level was so high that a much more radical shift would have been required to get knocked out of its secure first place position; the same conclusion would also apply to New York. Once again, the New Jersey data suggest that their rate setting law was accompanied by a significant infusion of new money into their hospital system. We will explore the reasons for this financial infusion in the final section of this chapter. The Maryland figure is consistent once again with that state's 20 year pattern of a lowering in hospital spending relative to other states.

B.4. Per Admission Short Term General Hospital Costs: The spending story unfolds further as we examine "per admission" cost patterns -- the rate setters' preferred terrain for evaluation because the numbers were more frequently favorable than per capita indicators:

Table 4.5: Per Admission Hospital Costs

	1982	Rank	1992	Rank
US	2883		5786	
MD	3210	10	5394	29
MA	4105	1	6198	7
NJ	2712	23	5732	15
NY	3607	4	7390	2

Chart 4.4: Per Admission Hospital Costs

Source: 1982, HCFA Office of the Actuary; 1992, AHA Annual Survey of Hospitals

The data for Maryland demonstrate what supporters of rate setting regard as their key success, reducing the per admission cost from above the national average to significantly below that standard, along with a substantial drop in their relative position among the 50 states, from one of the highest, to number 29 in 1992. Even policy makers in Massachusetts drew satisfaction in the drop in their relative position. During the early 1980s, when the Massachusetts rate setting system was at its most stringent, the drop was more substantial. However, the latter part of that decade saw significant hospital reflation because of political pressure from the hospital community, pressure which reversed much of the gains made earlier in the decade.

The data for New York confirm that rate setting did not hold down hospital spending over a ten year period -- this state's data resemble that of Massachusetts, including significant cost pressures during the early and mid part of the 1980s, and reflation in the latter part of the decade. The data for New Jersey confirm again that rate

setting -- at a minimum -- coincided with a significant inflation in hospital costs, even on this basic evaluative measure. A 1994 RAND analysis of the New York system suggests why the New York and New Jersey records should not be so surprising:

“At its broadest level, the success of all-payer rate-setting in controlling unit costs is not terribly surprising. The state, after all, is deciding how much hospitals will be paid per unit. If the unit price is set low enough, payer costs will be contained by definition.” [10]

Nonetheless, the data clearly indicate that three of the four subject states (Massachusetts, New Jersey, and New York) had difficulty making or sustaining progress on this key cost indicator. The following section on the case histories of rate setting in the states will seek to answer the question why.

B.5. Medicaid Expenditures as Percent of Total State Budget: The role of rising Medicaid costs in pushing states to adopt rate setting as a regulatory tool is difficult to measure in a quantitative fashion. While periods of fiscal stress where Medicaid has been a major budget culprit are easy to identify (Massachusetts in 1975 and 1991, New York in 1975), absolute measures of Medicaid’s impact on each state’s budget are highly variable depending on the measures used, as the following two examples demonstrate:

Table 4.6: State General Fund Medicaid Spending as a Percent of State Taxes (excluding gas taxes)

	% of State Taxes	State Rank
US	11.6	
MD	17.2	2
MA	16.0	4
NJ	14.3	6
NY	11.3	20

Source: National Association of State Budget Officers, in State Policy Reports, V12, # 11; June, 1994

Table 4.7: Medicaid Spending as a Percent of Entire State Budget

	% of Budget	State Rank
US	18.4	
MD	24.4	6
MA	21.3	11
NJ	19.6	18
NY	15.2	33

Source: National Association of State Budget Officers, in State Policy Reports, V12, #16, August, 1994

Depending on the measure, our subject states are either very high, or not high at all in Medicaid spending relative to other states, with only Maryland as high in both tables. New York's spending levels are lower than others because a substantial portion of the state share of Medicaid costs are paid by county government. The four states appear larger in Table 4.12 than in Table 4.13 because they only qualify for 50 percent reimbursement of their Medicaid costs whereas other states receive substantially greater levels of federal reimbursement and thus require less in direct state tax support.

As will be demonstrated in the narrative, Medicaid program considerations have played an important role in decisions about hospital rate setting regulation, though not strictly because of the above listed figures. For example, policy makers in Maryland -- where Medicaid costs are largest in the context of overall state spending and taxes -- were the least interested in Medicaid matters in making rate setting decisions among the four subject states.

C. Other Health System Characteristics: The other data presented below are

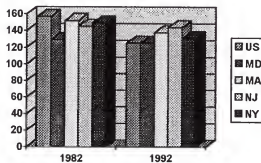
related to other hospital and health system characteristics of importance, and indirectly related to costs and levels of spending.

C.1. Hospital Admissions Per 1,000 Population: Hospital admission trends over a ten year period demonstrate another consistent impact of rate setting in the subject states:

Table 4.8: Admissions per 1,000

	1982	Rank	1992	Rank
US	157		125.3	
MD	129	42	125.4	24
MA	152	26	137.8	12
NJ	145	30	144.1	10
NY	149	29	131.1	15

Chart 4.5: Admissions per 1,000



Sources: 1982, HCFA, Office of the Actuary; 1992 AHA Annual Survey of Hospital

These data suggest several important conclusions: first, that the high cost of hospital care in 1982 in the subject states was not related to a high number of hospital admissions, since all four states were below the national average on this measure. Second, all four states saw their rate of hospital admissions drop during the ensuing decade, but none saw their rate drop as much as the change elsewhere in the nation. In fact, by 1992, all four states had moved from the bottom half to the top half of the 50 states in rate of admissions. This suggests that rate setting may have worked to keep the rate of

admissions higher than it would have been in regulation's absence -- a factor that partly explains its poor cost control performance in three of the four states. The lowering of costs attributable to rate setting in its early years in all four states may have created a higher level of demand and more admissions than otherwise would have occurred.

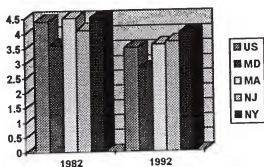
Also, it was during this ten year period that a pronounced shift from inpatient to outpatient services began to be observable across the nation, because of the introduction of Medicare DRGs and the emergence of managed care. Rate setting may have worked to slow this evolution somewhat in the subject states. If so, this would be consistent with the theory of economic regulation hypothesis that rate setting worked to protect more than to squeeze hospitals -- at least during the latter half of this ten year period.

C.2. Hospital Beds per 1,000 Population: Hospital inpatient capacity has historically been viewed as an important variable in explaining aggregate hospital costs. State Certificate of Needs laws restraining the growth of inpatient beds were mandated by the federal government in the early 1970s as a way to control the hospital spending spiral. Despite this belief, the number of hospital beds per 1,000 does not appear to be a major factor in explaining the cost picture or the expense growth trend relative to rate setting during the 1980s:

Table 4.9: Beds per 1,000

	1982	Rank	1992	Rank
US	4.4		3.5	
MD	3.6	36	2.8	41
MA	4.5	19	3.6	25
NJ	4.1	30	3.7	19
NY	4.5	19	4	15

Chart 4.6: Beds per 1,000



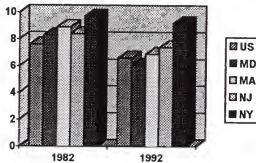
Sources: 1982, HCFA, Office of the Actuary; 1992, AHA 1992 Annual Survey of Hospitals

None of the hospital systems in the four states could be considered overbedded based solely on population calculations in 1982 or 1992. Maryland and Massachusetts saw a relative drop in beds greater than the nation as a whole, while New Jersey and New York saw a drop that was somewhat less than the national rate. Clearly all of the rate setting states were in sync with the national trend, and the rate of hospital beds would not appear to explain much of what is occurring in hospital finance in these states.

C.3. Inpatient Days per Admission: The four states stand out among the 50 in the category related to average hospital length of stay, though the story is not consistent among them:

Table 4.10: Length of Stay per Admission

	1982	Rank	1992	Rank
US	7.6		6.6	
MD	8.3	11	6.1	36
MA	8.9	3	6.9	9
NJ	8.4	9	7.4	3
NY	9.7	1	9.2	1

Chart 4.7: Length of Stay per Admission

Source: 1982, HCFA, Office of the Actuary; 1992, AHA Annual Survey of Hospitals

The rates in all four states are consistent with national trends, showing a reduction in average lengths of stay per admission. Once again, the Maryland rate outperforms the rest of the nation, dropping from well above to well below the national average during its peak rate setting years. Massachusetts also demonstrates a sizable drop, which may have some relation to the substantial growth of health maintenance organizations in the state during the latter half of the ten year period.

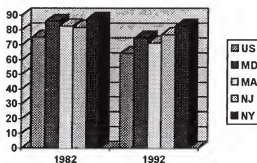
While both New Jersey and New York show drops, they are far less than the rest of the nation, again supporting the observed trend in these two states toward rate setting acting as a regulatory buffer for hospitals in the latter part of the 1980s. As we shall see, policy makers in New York were aware of their dubious distinction in having the longest hospital length of stay in the nation during the 1980s. As we will also see, steps were taken by regulators to reduce this rate; however, the AIDS and crack epidemics of the late 1980s have been identified by New York and New Jersey policy makers as new developments that frustrated their efforts to reduce this rate to more acceptable levels.

C.4. Occupancy Rates in Community Hospitals: The final hospital specific indicator examined in the four states is hospital occupancy. In this category, a consistent trend is observable:

Table 4.11: Hospital Occupancy Rates

	1982	Rank	1993	Rank
US	75.3		64.4	
MD	85.9	5	74.6	4
MA	82.8	4	71.3	9
NJ	81.8	7	77.1	3
NY	87.3	1	82.8	2

Chart 4.8: Hospital Occupancy Rates



Source: 1982, HCFA, Office of the Actuary; 1992, AHA Hospital Statistics

Hospital occupancy rates were high in the four states in 1982, and, while lowered, continued to be among the ten highest in the nation in 1993. The high occupancy rates may be attributable to several factors: first, during the 1980s, all four states maintained full certificate of need programs which, while frequently ineffective, may have had some restraining influence in expanding bed supply; second, rate setting programs provided an opportunity for public examination and discussion about excess hospital beds and occupancy rates that pressed state and hospital officials to seek to keep the occupancy ratio as high as possible; and third, as we will see, these four states all have physician to population ratios above the national average, a fact that could lead to the states' higher than average admissions rates and to higher occupancy.

C.5. Physician Data: The ratios of physicians to population in the four states -- both total and patient care -- are among the highest in the nation:

Table 4.12: Physicians Per 100,000

Total and Patient Care Physicians, 1992, Per 100,000				
	Total	Rank	Patient Care	Rank
US	247.2		203.7	
MD	373.8	2	295.2	3
MA	388.4	1	307.2	1
NJ	282.8	7	236.5	6
NY	363.2	3	297.9	2

Source: American Medical Association, 1992; in *State Level Databook on Health Care Access*, Urban Institute, 1995

In spite of the very high rate of physician presence among the 50 states, per capita expenditures for physician services are somewhat less extreme:

Table 4.13: Physician Costs Per Capita

Physician Costs Per Capita, 1991		
	Expenditures per Capita	Rank
US	598	
MD	676	9
MA	708	6
NJ	589	16
NY	588	18

Source: Health Care Financing Administration, Office of the Actuary, 1991

During recent discussions in New York State on the future of their rate setting system, it has been noted that while their hospitals costs -- subject to long term regulation -- have been consistently among the highest in the nation, their physician costs -- not subject to any state specific regulation -- are much further down in the pack. [11] This observation contrasts with a critique of New York rate setting that was made frequently during the 13 years of the that state's system: namely, that the failures of the system were tied to its failure to regulate physician and outpatient costs -- the clear suggestion being that inpatient costs were under control but were destabilized by growing out-of-hospital services. [12]

That critique does not wear well given the above listed data. In fact, we can

observe in the four states a reversal of circumstances with regard to hospitals and physicians. Regarding hospitals, the number of either institutions and beds is not excessive among the 50 states; nonetheless, costs, whether per capita or per admission (except for Maryland's) are very high in comparison with the rest of the nation. Regarding physicians, a very large number of them, practicing or otherwise, is not accompanied by excessive physician costs. This observation lends support to the suggestion that a higher ratio of providers may provide competitive pressure for lowered rates of overall spending; by contrast, a non-excessive supply of facilities and bed, constrained by a tight certificate of need law, may actually encourage a higher rate of spending, once again lending weight to the cartel theory as one explainer of high hospital costs.

C.6. Health Sector Employment as Percent of Total Employment: Data indicate that health sector employment as a percent of total state employment is higher than average in all four states, though much higher in Massachusetts and New York than in Maryland and New Jersey. According to Bureau of Labor Statistics data, with a US average of 7.9 percent, Massachusetts was near the highest with a 10.3 percent health sector share of total employment; New York was at 8.8 percent, Maryland at 8.2 percent and New Jersey at 8.1 percent. [13]

Higher rates of health care employment may lead to a greater concern among policy makers regarding the performance of the health sector as part of the overall economy. The four rate setting states uniformly exhibited concern among policy makers for the stability of the hospital sector, both to avoid large layoffs and to ensure its continued vitality. This is most clearly evidenced by the statutory requirement in Maryland that rate regulators work to ensure the financial stability of hospitals. Higher rates of health sector employment also create a stronger stake in the sector's performance by organized labor, both to protect existing unionized workers and to take advantage of future organizing opportunities.

C.7. Population Not Covered by Health Insurance: Rate setting was intended to bring lower levels of hospital spending than would have occurred in its absence; the lower costs were expected to make health insurance more affordable for those without it. The results were more mixed. Data on the levels of uninsurance among the under-65 year old population add another dimension to our understanding of the context in the rate setting states:

Table 4.14: Population Uninsured

	1991	Rank	1993	Rank
US	14.4		15.3	
MD	13.2	23	13.5	22
MA	11.1	33	11.7	39
NJ	11.0	35	13.7	21
NY	12.7	28	13.9	20

Source: US Bureau of the Census, Health Insurance Coverage, 1993: Statistical Brief: SB/94-28; October, 1994.

All of the four states have levels of uninsurance below the national average. Perhaps the more important observation is that in spite of extensive and intrusive rate setting programs, none of these states is in the top tier of states with low levels of uninsured persons. The best performer among the four is Massachusetts, primarily because its drop in levels of insurance coverage in the early 1990s was less than that of other states. (This performance has also declined in recent years.) The other three all saw their rank drop in the past several years.

This finding, upon reflection, should not be surprising. Rate setting programs, while paying key attention to issues such as provision of uncompensated care to medically indigent persons, are initiatives focused on *institutions*, as opposed to efforts in others states (i.e.: Hawaii, Minnesota, Oregon, Tennessee) that focus reform initiatives more directly on the provision of services and insurance coverage to *persons*. Indeed, the genesis of the uncompensated care pools in rate setting states had more to do with institutional bad debt constraints than with the needs of the uninsured. This will be addressed more specifically in the stories of the state programs in the next section.

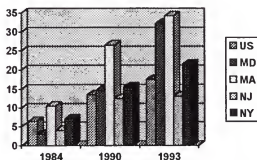
As we examine the aftermath of rate setting deregulation in Massachusetts and New Jersey, as well as recent discussions on a successor statute in New York, much more emphasis is evident on finding appropriate means to provide insurance coverage to individuals and families, and far less attention is paid to the financial needs of institutions. As rate setting approaches are abandoned, states are more likely to move in the directions taken by other reform states such as Minnesota, Tennessee, and Oregon.

C.8. Growth in HMO Penetration, 1984, 1990, 1993: The final health-related data presentation involves the development of health maintenance organizations in the subject states. Penetration refers to the percent of state residents who are enrolled members in health maintenance organizations. Because of the role that managed care played in undermining the stability of regulation systems, the rapid development of HMOs during this period is critical to understanding the fate of rate setting in the four states:

Table 4.15: Percent HMO Penetration, 1984, 1990, 1993

	% 1984	Rank	% 1990	Rank	% 1993	Rank
US	6.4		13.5		17.5	
MD	3	21	14.7	15	32.2	4
MA	10.5	6	26.5	2	34.2	2
NJ	4	17	12.5	20	13.1	24
NY	7.1	10	15.5	12	21.5	12

Chart 4.9: HMO Penetration, 1984, 1990, 1993



Sources: 1984 & 1990: Interstudy, *Managed Care: A Decade in Review, 1980-1990*, 1993, GHAA, *Patterns in HMO Enrollment* 4th Edition, June, 1994.

A number of important observations can be derived from these data. The first is that, with the possible exception of New Jersey, it would be difficult to assert that rate setting held down the growth in managed care in the subject states. Massachusetts' performance is the principal evidence for this observation; this state had an HMO penetration rate below the national average in 1981 (4.0 vs. 4.5%), and saw its HMO penetration rate balloon during its prime rate setting years. In fact, it is plausible that a design feature of the Massachusetts model that permitted HMOs to escape rate setting's charge controls actually encouraged the rapid development of HMO presence in the State.

The second observation is that with the exception of Maryland, the other states maintained their relative position among the 50 states consistently during this 10 year period. New Jersey's rate slipped a little, and Massachusetts and New York held their relative position. But Maryland went from being below the national average in 1984 (4 vs. 4.5%) to having the fourth highest penetration rate in 1993, despite a strong rate setting system that, unlike Massachusetts', did not permit any excess discounting by any parties to the system. A number of explanations were offered by interviewees for this unexpected phenomenon. These included the state's high proportion of federal employees who were given strong incentives during the 1980s to join HMOs and the state's relatively high cost structure that permitted HMOs to attain profits by outperforming the fee-for-service sector. The former explanation is consistent with data on the numbers of federal employees in the state; the latter explanation does not square with the data presented in this section that show low costs per capita and per admission, and low lengths of stay.

The third observation is that, given the performance of Massachusetts and Maryland, it is unclear why New York and New Jersey did not see a far greater growth in HMO penetration. Interviewees in both states suggested that managed care has had a difficult time getting off the ground in the New York City metropolitan area (including northern New Jersey). The observed growth in HMOs in New York can be attributable to upstate/non-New York City population areas; in New Jersey, the non-NYC metropolitan

areas holds far less population than the New York City area. In the New York City area, high levels of unionized workers together with a strong fee-for-service culture have been suggested as combining to slow the growth of managed care, a dynamic that did not occur in Massachusetts.

C.9. Legal Status of Hospitals: Another feature of the four states deserves mention, but does not need any explanatory charts. As late as 1995, all acute hospitals in all of the four states were not for profit. New York specifically has a statute dating back to the 1950s which bans any for-profit entity from owning a licensed acute care hospital in the state. In the other three states, the mere existence of rate setting programs worked to discourage for profit hospital corporations during the 1980s from seeking to buy any not-for-profits in the subject states. In 1995, the large for-profit hospital chain, Columbia-HCA, made the first bid to purchase an acute hospital in any of the four states -- in Massachusetts, which deregulated its rate setting law in 1991.

D. Political Characteristics:

D.1. Political Culture: Elazar has established a well known set of political culture categories for all 50 states according to three general groupings: the *individualistic* political culture emphasizes the public sphere as a marketplace, one that places a premium on limiting government intervention into private activities, and on adopting a business-like conception of politics; the *moralistic* political culture emphasizes the commonwealth and communitarian values, with government seen as a positive instrument to promote the general welfare, and political participation viewed as a moral obligation; finally, the *traditionalistic* political culture adopts paternalistic and elitist views of the state and an ambivalent view toward both the marketplace and public bureaucracies. These categories are intended to define the dominant traditions that each state regards as proper government activities. [14]

In Elazar's rankings, New Jersey and Maryland are identified with other mid-Atlantic states as "Individualistic Dominant" while Massachusetts and New York are listed as "Individualistic Dominant, strong Moralistic Strain." This ranking is mentioned here primarily because of the prominence that it has attained in research on the states. Its application in this study is questionable, especially given the four subject states' track records on innovativeness (see next section). Rather than being reticent about inserting government into the marketplace, the four subject states are among the most interventionist of the 50. While the recent move to deregulation in Massachusetts, New Jersey and New York can be viewed as being in the Individualistic direction, there has been no broad-based retreat from an activist government orientation, even among most recent group of Republican governors. Most questionable would be the categorization of Maryland as Individualistic, the state that, for example, has enacted the largest number of health insurance-mandated benefits in the nation.

D.2. Political Innovation Scores: Attempts also have been made to rank the 50 states according to their track records in adopting new programs and laws that have been approved by other states. Two of the most recognized indices, one from 1969 and the other from 1973, are presented below because of the consistency among the subject states in the rankings:

Table 4.16: State Ranking on Innovativeness Indices

	Walker Ranking, 1969	Gray Ranking, 1973
Maryland	#16	#15
Massachusetts	#2	#3
New Jersey	#4	#4
New York	#1	#2

Sources: 1969, Walker, Jack. L. "The Diffusion of Innovations among the American States", *American Political Science Review* V.63, N.3, 880-895. 1973, Gray, Virginia. "Innovation in the States: A Diffusion Study". *American Political Science Review* V.67, N.4, 1174-1185.

The results indicate that the four subject states are among the highest in terms of adopting new programs and laws more readily than others. These rankings are useful and

appropriate because they reflect the general time period when rate setting policies were formed and programs were established. While Maryland's ranking is in the top third of all 50 states, the other three are in the top four in both sets of rankings. Walker's index is based on an analysis of 88 different programs in eight areas enacted by at least 20 states prior to 1965. In his analysis, the key variables that correlate with innovativeness are demographic and not political: "...the larger, wealthier states, those with the most developed industrial economies and the largest cities, would have the highest innovation scores." [15] Gray's index is based on adoption of new programs in three areas: education, welfare policy, and civil rights. [16] It should be noted that the consistency between the two indices regarding the four subject states did not hold up regarding the other 46 states, which showed significant variability between the two sets of rankings.

These rankings indicate an openness in the four subject states toward experimentation with new programs and initiatives, as well as a generally liberal and activist orientation on matters of social policy. It is not surprising, given this indicator, to find the subject states in the innovator category with regard to establishing hospital rate setting programs, and setting national models. Even during periods of Republican control, such as the Rockefeller years in New York State and the Kean years in New Jersey, the four subject states maintained liberal, pro-regulatory political profiles.

General Conclusions: All four of the subject states are located in the northeastern region of the nation, are large and heavily urbanized, and enjoy high personal per capita incomes. While there have been periods of Republican rule in the executive and/or legislative branches, the states can be characterized as relatively liberal in political orientation, and Democratically influenced, particularly during the formative years of rate setting development. At the time of rate setting's establishment, they were innovative, interventionist states that looked to government at all levels to meet social needs and to solve pressing social problems.

In the late 1960s and early 1970s, health care and hospital costs were very much on the public's list of serious state and national problems. Currently, and since the late 1980s, all four states have had very high levels of health care expenditures per capita; this represents a change only in the case of New Jersey, which had much lower relative spending levels between 1972 and 1982. Also currently, Massachusetts, New Jersey and New York face high hospital costs on a per admission and per capita basis; again, this represents a substantial shift in the case of New Jersey. Maryland has seen a major drop in its very high level of hospital costs in the mid 1970s, sharply different from the trend in the other three states.

On other hospital measures, the subject states can be characterized as high in rate of admissions (except for Maryland), high in length of stay (except for Maryland), and high in hospital occupancy. All four states have a lot of physicians, but not unusually high physician costs. As predicted, the states seem to pay more than average for their Medicaid programs, though scores vary on this count depending on the measure used. Their levels of uninsurance are a little better than the national average, but not by much. Finally, except for New Jersey, they all have HMO penetration rates greater than the national average, and a lot greater in the cases of Maryland and Massachusetts.

Based on this data and information alone, it should not be surprising that Maryland is the only state of the four where rate setting still appears to be secure and supported by the political structure. The data show that the program has been accompanied by a significant drop in relative hospital expenditures, and appears to have met its key objectives. The data indicate that rate setting has been accompanied by serious levels of hospital cost inflation in New Jersey, and no change in high rates of expenditure in the case of Massachusetts and New York. It thus also should not be surprising that the rate setting programs in those states faced a much rockier path. In the next section, the fuller story of rate setting in all four subject states will unfold.

Cases Histories of Rate Setting in the States

As the data in the previous section suggest, the individual case histories of rate setting in the subject states do not fit into a simple linear pattern. On some variables, the four states are uniform; but on many other characteristics, they group with each other in every possible variation. Our ability to identify these patterns and inconsistencies is helpful in relating the individual histories of rate setting and also in understanding the lessons for health policy from this long experience. From our current day vantage point, we can view these data and reach strong conclusions about the effectiveness of these four systems. But policy makers in 1975 and 1985 had far less ability to predict the future directions in which their systems would move. Rather, their decisions were based on incomplete, anecdotal, and frequently contradictory information and pressures. Were the rate setters and their supporters on the cutting edge of a new health system financing structure, or were they holding together the remnants of a failing regulatory model? In this section, the cases of rate setting in the four states are presented to give the context in which those legislative and regulatory decisions were made.

Rather than relating the full history of rate setting in each state in turn, this overview of the development and history of the four programs will be woven together thematically, so that the similarities and differences can be observed at each stage of development. The structure for this section will borrow from organizational theory, and in particular an adaptation of Miller and Friesen's "Life Cycle Stages Model." [17] Their model suggests four stages in the corporate life cycle, which is adapted here to present a "regulatory life cycle." The stages are: birth, growth, maturity, and revival/decline. While some identified characteristics of each stage are inappropriate when applied to a governmental structure, (i.e.: market segmentation, more owners, diverse board) others are appropriate for our discussion; they are listed below:

1. Birth: the period leading up to the enactment of the first mandatory rate setting

statute, characterized in the model by frequent innovation, finding unfilled niches, small in size, simple centralized structure, and risk taking behavior;

2. Growth: the period of program implementation and establishment of key structures and relationships, characterized in Miller's model by incremental innovation, lobbying activities, increased size, functional structure, increased staff, and less risk-taking;

3. Maturity: the period of seeming programmatic stability, characterized by few changes, large size, diverse board, functional structure, professional managers, less delegation, efficiency emphasis, and conservative decision making; this period also precedes decline and deregulation in three of the subject states;

4a. Revival: the period characterized by many innovations, diversification, large, divisional structure, decentralized operations, increased scanning, and renewed risk-taking; in this example, only Maryland fits into this category;

4b. Decline: the period -- including Massachusetts, New Jersey, and New York -- characterized in the Miller model by outdated products, shrinking markets, no particular strategy, centralized, little scanning, extreme conservatism, little innovation, and risk taking abhorrence.

None of these stages or characteristics is inevitable in all situations; however, the framework is a useful tool to describe rate setting's development in each state, with one important modification. In Miller and Friesen's model, revival is presented as the stage prior to decline. For the purposes of this review, revival and decline will be presented as either/or propositions, with Maryland being the sole example among the four of a potential revival scenario.

One other important feature in relating the stories from the states is that the dates of critical events are not as clear-cut as the above model would suggest. For example, three of the four states had statutes relating to hospital and health insurance cost controls prior to adoption of the mandatory all-payer model discussed in this research; also, a time

lag existed between enactment and actual implementation. In each of the four cases, successor statutes established important structural modifications to each state's program. Even deregulation was a phased-in affair in the two states that have accomplished that objective. Table 4.16 (on the next page) presents the key events in the four subject states in summary form.

The category "Enactment of First Mandatory RS Statute" is not as precise as it would appear in the cases of Massachusetts, New York and New Jersey where mandatory controls were established first for Blue Cross and Medicaid, and later for other commercial payers. The category "key successor statutes" includes statutory revisions that established significant structural changes.

Birth: A review of essential documents and literature on rate setting in the four states makes clear that identifying an actual birth date for three of the four systems is a judgment call. On the most basic level, legislative enactment and regulatory implementation were years apart. Additionally, all states except Maryland had a series of related hospital and insurance statutes, one dating as far back as the 1930s, making clear that the development of mandatory rate setting, while clearly a watershed, was also part of an evolutionary chain.

The motivation for the establishment of formal prospective rate setting differed from state to state. Massachusetts and New York policy makers developed their systems largely in reaction to severe cost crises within their Medicaid programs. Maryland legislators moved in concert with hospital officials to respond to rising private sector hospital costs and to avert more intrusive federal controls. New Jersey had elements of all three dynamics at work. We shall also see that while interest groups were involved and aggressive, the search for a better *idea* by which to control rising hospital costs appeared to rule the day.

Maryland: Among the four subject states, the genesis of the Maryland system is the clearest to track. In 1971, the State's General Assembly enacted legislation to

establish the Health Services Cost Review Commission (HSCRC) to perform rate regulation of inpatient hospital charges. After three years of regulatory development, the

Table 4.17: Key State Rate Setting Developments

	<i>Key Predecessor Statutes</i>	<i>Enactment of First Mandatory RS Statute</i>	<i>Implementation</i>	<i>Key Successor Statutes</i>	<i>Deregulation</i>
MD	na	1971	1974	1978: all payer to include Medicare and Medicaid 1980: Congress incorporates Medicare waiver into statute; 1986, 1991: Federal statute modified to protect waiver	na
MA	1953: Bureau of Hosp. Costs & Finances set up; 1968, 1973: Rate Setting Commission established, reorganized	1975: 1976	1977	1982: all payer rate setting & Medicare waiver; 1985: uncompensated care pool established; Medicare waiver lost; 1988: universal health care law, UC pool capped; rate setting continued until 1991	1991: enacted; 1992: implemented
NJ	1938, 1963: Blue Cross per diem limits; 1969: hospital budget review	1971	1975: DoH control 1976: SHARE	1978: all-payer system enacted; 1980-82: DRG phase- in 1985: UC Trust Fund created 1989: Medicare waiver lost	1992: enacted; 1993: implemented
NY	1966: Article 28 reimbursement framework	1969	1971	1978: Commercial payers added 1982: NYPHRM I, all payer, Medicare waiver; 1985: NYPHRM II, loss of waiver; 1988: NYPHRM III, from per diem to per case payment; 1991: NYPHRM IV, expanded use of pool 1994: NYPHRM V	1996: likely

HSCRC began performing rate reviews in 1974 for Blue Cross and charge payers. The system was modified in 1978 to include all public and private payers including Medicare and Medicaid under its purview. [18]

The key motivations for enactment of the new system in 1971 appear to be twofold: first, a desire by legislators to rein in rising hospital costs, a concern that dates to the mid-1960s with the establishment of Medicare and Medicaid and the accompanying surge in hospital costs; and second, a desire by the hospital industry to avert more intrusive federal controls that they feared were in the offing.

Bills had been filed to begin hospital rate regulation as early as 1967 when Delegate Rosalie Abrams filed HB515 to establish a Council for Hospital Affairs with broad powers to regulate hospital charges. While unsuccessful, an increasing number of bills were introduced in succeeding years by additional legislators to address hospital rate increases, most of them demonstrating increasing sophistication and depth. All of the proposals were strongly opposed by the Maryland Hospital Association which was, up until 1970, an adjunct organization of Maryland Blue Cross which funded about half of the MHA's operating budget. [19]

The year of pivotal change in the state was 1971. First, Governor Marvin Mandel announced in his state of the state address that hospital rate regulation would be "the cornerstone" of his consumer protection legislation. Second, the hospital industry did an about face, choosing to back rate regulation after years of opposition, and writing the bill that became Maryland's hospital rate setting statute. A principal reason for this change can be traced to the reorganization of the Maryland Hospital Association in 1970, which removed Blue Cross' controlling interest, and also placed hospital trustees in control of the organization instead of hospital chief executive officers -- a structure which persists today and is unique among the 50 state hospital associations. [20]

A Baltimore attorney who was one of the MHA trustees involved in the drafting of the bill in 1971 remembers the process well:

"The dirty secret is that the legislation was drafted by the Maryland Hospital Association ... The genesis had to do with its (MHA's) desire to avoid national regulation in which the hospitals would be treated in groups

rather than individually. There was a strong feeling that national regulation would not be responsive to Maryland's needs."ⁱⁱ

The new MHA leadership determined that retrospective cost reimbursement was ineffective and lacking in efficiency incentives, and that prospective rate setting was a more effective alternative. Also a growing fissure between hospitals and Blue Cross was at play. Richard Davidson, now President of the American Hospital Association, and a long time executive of the MHA, noted that prior to state rate setting, Blue Cross exerted "regulation in its most primitive form ... Third parties had been doing the regulating for years through rules and regulations, application of the reimbursement formulae, and through a general authority that permitted them to proclaim 'We will pay for what we will pay for.'" [21]

The key opponent to passage was Blue Cross which felt that it would be compelled to pay more to hospitals than it did under the prior arrangements. In particular, the large insurer objected to provisions allowing hospitals to include bad debts in their calculation of allowable charges. In the words of Blue Cross' lobbyist at the time, Fred Gloth, "The hospitals got together and wrote up the best legislation they could perceive -- it guaranteed profit and success." Davidson's stated view was that "Blue Cross viciously lobbied against the bill and used dirty politics." [22]

Two special features of the Maryland statute are important, especially in relation to the other states: first, the statute did not spell out in detail the requirements of the new system, but instead left substantial discretion to the HSCRC, a feature that provides important flexibility to the regulators to respond to negative feedback; and second, the statute was not given a sunset, and thus required no reauthorization by the Maryland legislature, a feature that enhanced the clout of the regulators in setting the rules. The

ⁱⁱ Interview with Eugene Feinblatt, Gordon: Feinblatt, Rothman, Hoffberger & Hollander, LLC, Baltimore, 6/21/95.

Legislature, through both of these features, took themselves largely out of the control and governance of the new system.

Rate setting was born in Maryland because of the convergence of a series of developments: the growing concern about rising hospital costs, among the highest in the nation at the time; the presence of political leaders, including the new Governor, who made enactment of rate setting a legislative priority; and a changed structure and policy agenda at the Maryland Hospital Association, combined with an altered Blue Cross relationship.

Massachusetts: Massachusetts was one of the earliest states to move in the direction of hospital reimbursement regulation. In 1953, the Legislature established the Bureau of Hospital Costs and Finances which, among other duties, set reimbursement rates for the medical bills of indigent welfare recipients. In 1956, the Rate Setting Board was established to set rates for nursing, convalescent, and rest homes. At some point during the 1960s, the Board also began to audit hospitals for Blue Cross.

Medicaid was launched in the Commonwealth in 1967 with implementation duties shared between the Departments of Public Health and Public Welfare. Legislation was passed in 1968 to create an independent Rate Setting Commission to coordinate and centralize rate making and auditing functions that had previously been performed by the many different agencies that purchased health care services and to assure "that the rates of payment and reimbursement will give both full value received for every taxpayer's dollar spent and at the same time provide the fair and equitable compensation to the hospitals and other vendors of services." ⁱⁱⁱ

The new Commission was given authority to set rates paid by governmental units as well as industrial accident rates. At that time, the RSC was also empowered to approve

ⁱⁱⁱ Governor's Special Message, 1967

Blue Cross contracts with hospitals. A 1973 law reorganized the Commission, replacing five part-time commissioners with three full-time commissioners, and providing expanded authority to approve rates for all social, educational, and rehabilitative programs purchased by governmental units.

The new Commission moved rapidly to assume its new responsibilities. For example, Massachusetts was one of the first states to receive a waiver from the federal government to set hospital Medicaid rates that were different from Medicare rates. Beginning April 1, 1974, Massachusetts implemented a prospective per diem methodology with occupancy minimums for all Medicaid reimbursements to hospitals. In 1976, the Commission received a \$1 million grant from the federal government for a demonstration project to develop refinements to the prospective reimbursement system.

For the Commonwealth, 1975 was a critical year in the establishment of mandatory hospital rate setting. A very severe recession, accompanied by a deep budget crisis and a sizable personal income tax hike, focused major attention on the rising costs of the Medicaid program within the state budget. Because Medicaid represented only about ten percent of total hospital costs in the state, the Legislature decided to give the RSC authority to control the total amount that hospitals charged for their services. Newly elected Governor Michael Dukakis had sought legislation to place a freeze on hospital charges, a proposal strongly opposed by the Massachusetts Hospital Association (MHA). The temporary system (chapter 424) approved in 1975 as a compromise was followed in 1976 by a longer term model (chapter 409). As Kronick notes, "The main reason for enacting this system was to control Medicaid expenditures." [23]

This assessment of the 1975 process is confirmed by an observer who was present at the time:

"In 1975, the idea was, 'Let's try and put Medicaid on a better footing'. To do it, we had to put controls on the overall system. It's been a consistent theme over 18 years that one of the key drivers had always been

trying to control Medicaid: 1975 to 1991 through rate setting, and after 1991 through managed care."^{iv}

The contrast with Maryland is noteworthy. Massachusetts policy makers sought to control all hospital charges as a means to constrain most effectively their own priority, the budget costs related to Medicaid. Maryland policy makers, by contrast, sought to control charges as a means to slow down both hospital and health cost inflation; slowing the growth of Medicaid was not a central aspect in their thinking.

New Jersey: In New Jersey, controls on hospitals were initially related only to Blue Cross rates, dating back to 1938 when the state first established its authority to regulate subscriber premiums. By 1963, the first per diem limits on Blue Cross hospital payments were set at \$56 following several large rate hikes. Hospitals exceeding the cost limit could appeal through a review process run by the New Jersey Hospital Association (NJHA). [24]

In the late 1960s, even with this minimal system, the State had a taste of pressures and challenges to come as hospitals complained of an inability to keep within the \$56 limit because of rising medical inflation, and of the failure of the system to recognize case mix differences among hospitals that served widely varying populations and needs. Regulators as well as hospital leaders regarded the retrospective structure of the system as problematic. Also, the regulation of only Blue Cross and Medicaid (added in 1965) led to cost-shifting concerns among commercial insurers and self-pay patients. [25]

In response to these concerns, the NJHA and the Commissioner of Insurance established in 1969 an oversight process of hospital budgets, with special reviews for hospitals exceeding the recommended growth ceilings. The review process was conducted by the Hospital Research and Educational Trust (HRET), an NJHA affiliate, with results reported to an Insurance Commissioner-appointed Advisory Committee. [26]

^{iv} Interview with Steven Tringale, former Blue Cross, Life Insurance Association, Legislative Staff, Boston, 12/21/94.

Facing serious financial distress, Blue Cross concluded that these controls were insufficient and began to promote a proposal for state run mandatory prospective budget review. Despite hospital resistance to direct state involvement, the 1971 Health Care Facilities Planning Act established both mandatory certificate of need and hospital rate setting -- Blue Cross and Medicaid hospital rates required approval of the Commissioners of Health and Insurance, with regulations established by a new, 13 member Health Care Administration Board to be appointed by the Governor. [27]

While Blue Cross and the State achieved their objectives in terms of establishing direct state control over hospital budgets for the first time, hospitals were winners as well in seeing the establishment of a certificate of need program that would work to keep out of the state the threatening for-profit health providers who might undermine non-profit market control. The emergence of mandatory controls thus represented a convergence of concerns and interests, including fast rising hospital costs and overall medical inflation, financial instability for Blue Cross, and rising Medicaid costs on the part of the state government.

In spite of the passage of the 1971 landmark legislation, New Jersey policy makers left the NJHA-affiliated HRET as the operator of the budget review system. This relationship was finally disrupted in 1974 with the publication of a book, Bureaucratic Malpractice, which brought attention to the failure of the Governor William Cahill's Administration to implement effectively the 1971 law which envisioned a regulatory model that would be independent of hospital control. [28] Newly elected Governor Brendan Byrne committed his Administration to correcting the state's neglect of its role, and appointed Dr. Joanne Finley as Commissioner of Health to demonstrate a resolve to stand up to the hospital industry. Finley had served as Commissioner of Health in New Haven, Connecticut, and was familiar with ongoing research at the Yale School of Public Health to move from *per diem* to *per case* reimbursement methods, referred to as Diagnostic Related Groups (DRGs). [29]

In 1975, the Department of Health took over administration of the rate setting process, grouping hospitals into comparable categories to hold reimbursement to the median cost of each category plus a modest inflation factor, proposed at 2.5 percent for 1975. [30] A political brawl erupted between state regulators, who threatened to provide hospitals with less money than the Department of Health proposal, and the hospitals who filed lawsuits seeking retroactive adjustments. In the end, Governor Byrne backed down, and the hospitals received an average 12.5 percent rate increase. [31]

In 1976, the DoH implemented its first full mandatory rate setting program known as the Standard Hospital Accounting and Rate Evaluation System (SHARE) which required a detailed and complex budgetary review of hospital financial operations that exceeded a prior allowable rate of increase. Devine-Perez notes that "(T)he SHARE system represented the dramatic change which had occurred in the state's financing system over a few years. The locus for control over the state's hospital financing system had shifted from the industry, to a state-supervised and increasingly bureaucratic process." [32]

Different from the experiences in Maryland and Massachusetts was the prominent role played by Blue Cross in New Jersey in pushing for establishment of the system. Maryland Blue Cross opposed creation of its rate setting system, and Massachusetts Blue Cross was largely silent. Also different was the extent of hospital involvement in forms of rate and budget review long before the full mandatory controls came into play in the mid-1970s.

New York: The roots of the New York rate setting system trace back to 1966 with the establishment of Article 28 of New York's Public Health Law and the creation of the framework for hospital reimbursement for inpatient and outpatient rate setting functions. The State Hospital Review and Planning Council was created at this time to implement the new system, and given powers to require rate approvals. Adoption of these new structures followed the release of recommendations from Governor Nelson Rockefeller's

1964 Governor's Committee on Hospital Costs that had been directed to examine the reasons for spiraling hospital costs and the role of state agencies in addressing this problem. Concerns in the state accelerated in the late 1960s with the establishment of the Medicare and Medicaid programs, and a growing awareness of the need to provide hospital services to uninsured persons. [33]

While earlier attempts to control Medicaid spending had failed, in 1969 the State adopted its first prospective payment law that gave the Health Department statutory authority to certify reimbursement methodologies for both Medicaid and Blue Cross. Blue Cross in New York consists of five separate plans, and has historically enjoyed a large market share; for a long time, these plans maintained a policy of community rating for all individual and small group policies, suffering adverse selection because of that position. (In 1992, the State mandated full community rating on all regulated insurers, with the strong support of the Blue Cross plans.) To aid Blue Cross in maintaining this position, the State established a mandatory discount on the insurer's hospital charges, relative to other commercial carriers, to enable them to price competitively despite its enrollment of sicker and more costly individuals. [34]

As part of the 1969 legislation, the State "coupled" both Blue Cross and Medicaid rates according to the prospective per diem formula. As a result, Medicaid and Blue Cross' rates were nearly identical and below that of commercial payers who were required to cross subsidize this arrangement. The rates of the two large payers would remain coupled until the mid-1990s; as we shall learn, the coupling had serious consequences for the state's health financing system. [35]

The hospital industry, through the Hospital Association of New York (HANYs), opposed the imposition of these controls on its members, but was unable to prevent them because of legislative and executive concerns relative to Medicaid spending. Another portion of the 1969 legislation eliminated Medicaid eligibility for 390,000 individuals, or 14 percent of the potential recipient pool. In 1970, the federal government granted a

waiver to the State to implement its new system as the basis for calculating Medicaid payments. [36]

Summary Comments at Birth: We can observe during this phase a clear evolution toward broader, more intense, and more complex regulation even during the respective birthing periods in the four states. Perhaps most noteworthy is the range and differentiation of experiences of these four states in adopting and adapting regulatory models that are most often viewed from afar as similar and easily comparable. As we shall learn, the variation had only just begun!

Viewing this phase of rate setting's developments in the context of the theory of economic regulation, we can observe significant interest group activity at the birth of rate setting -- especially on the part of the hospital industry and Blue Cross -- but not in a consistent fashion. In Maryland and New Jersey, the hospital industry was hugely influential, at least in the early stages of rate setting development, while the same forces in Massachusetts and New York had these systems imposed on them. Concerns about the stability and solvency of Blue Cross were high in New Jersey and New York, while in Massachusetts, those concerns were not in evidence, and in Maryland, Blue Cross opposition was largely ignored. It is difficult to suggest from these summaries that these systems were created at the behest of the regulated industry -- the hospitals.

Regarding punctuated equilibrium, we can observe that in Massachusetts and New York, Medicaid was a central, driving concern in moving policy makers toward more aggressive, mandatory rate setting. In Maryland and New Jersey, more general concerns tied to rising hospital and health costs were of primary importance. In all cases, what emerges most clearly is a dissatisfaction with the prevailing reimbursement mechanism, retrospective cost-based reimbursement, as a means to address rising Medicaid and hospital costs. We can observe in all four states the deliberate and at times clumsy embrace of a new idea, namely prospective payment, as a more effective organizing principle for hospital reimbursement. We can also recognize the *lack* of any voices

calling for competition, payer pressure, negotiated payments, or any other alternative as a means to slow the growth in expenditures.

Growth: The following discussion covers the time period in the four subject states from implementation of the first mandatory rate setting law until the implementation of all-payer rate setting including the Medicare waiver from the Health Care Financing Administration. What should be most apparent during this and the subsequent section on maturity will be the narrowing of the range of interests directly involved in the development and maintenance of these systems; the intensity of interest within these narrow groups increased during this period. With the basic policy idea established and settled, policy makers and key interest groups were required to bear down to agree upon and to develop the infrastructure necessary to manage these complex regulatory arrangements.

Maryland: After enactment, the competition between Blue Cross and the hospital community abated. In establishing their rate setting program, Maryland policy makers had both the luxury and burden of implementing a broadly worded statute requiring only that hospitals be reimbursed based on the "reasonableness" of the relationship between costs and services, as determined by the HSCRC. Nine major duties were defined for the HSCRC:

1. to review and approve all rates and costs and charges for inpatient hospital services;
2. to adopt in regulation 'uniform accounting and financial reporting systems';
3. to perform periodic analyses and studies relative to health care costs, the financial status of hospitals, and more;
4. to 'promote and approve alternative methods of rate determinations and payment of an experimental nature' at the Commission's discretion;
5. to receive annual disclosure by each hospital of its financial position;
6. to issue annual reports on transactions between facilities and trustees;
7. to make note of certain financial transactions valued at more than 50% of a facility's assets; and
9. to issue an annual report on the Commission's activities.

The close relationship between the new regulatory structure and the hospital industry was highlighted by wording in the enabling statute that directed the Commission to ensure the solvency of all "efficient" hospitals in the State. But perhaps even more significant was the appointment of a hospital chief executive officer, Alvin Powers, as the first chairman of the seven member HSCRC. His appointment was a signal to the hospital industry that they had a friend at the helm of the Commission, but it also ensured that the regulators had a leader who was intimately familiar with the workings of hospital finances. The appointment also created concerns among non-hospital observers that the HSCRC would lean too much in the hospitals' direction.

From 1972 to 1977, the Commission developed and implemented their budget review model, while actual rate reviews began in July, 1974. A key part of the growth period included surviving a series of court challenges by segments of the hospital industry that were opposed to rate setting decisions. Though a few of these challenges played out until as late as 1983, a key decision came from the Maryland Court of Appeals in May, 1977 upholding the Commission's rate review authority. "The Commission is not required to defer to the hospitals' view of reasonableness in cases of conflict," the court ruled.^v

In 1974, the Commission began negotiations with the then-Department of Health Education, and Welfare to receive a waiver of Medicare and Medicaid reimbursement rules to permit federal payments according to the new state procedures. After three years of negotiation and lobbying by the Commission, the Governor, the hospital industry, and the Maryland Congressional delegation, the waiver was granted effective July 1, 1977. Because of the waiver, all payers, including Medicare and Medicaid, began to contribute to subsidizing hospital uncompensated care costs. [37]

^v Baltimore Sun, May 5, 1977

At that time, the new Department of Health and Human Services required annual reapproval of all Medicare and Medicaid waivers, a process that state officials found difficult to face:

“...They (HHS) were requiring reapproval each year ... Each subsequent year we didn’t hear from HCFA until after the deadline. It created tremendous turmoil for everyone in the state to be operating after July 1 without knowing. (Congresswoman) Barbara Mikulski came up with the bright idea, why the hell don’t we just put it in legislation. The rest of the delegation also became supportive.”^{vi}

In 1980, the Maryland waiver became Section 1814(b) of the Social Security Act, and specifically required in statute that the rate setting system not result in greater Medicare expenditures than would have occurred under the prevailing Medicare reimbursement methodology. None of the other states that received Medicare waivers even attempted to place their special status into federal law. As we shall see, this was one of the most significant developments in the history of the Maryland system.

Massachusetts: Unlike Maryland, the Massachusetts rate setting model established under the 1976 statute, Chapter 409, came under rapid, increasing pressure and dissatisfaction. While the rules provided a ceiling on payments from Blue Cross and public payers, hospitals were allowed to cover their losses from bad debt and free care through add-ons to commercial insurers and self-pay patients. Commercial insurers, who had never been heavily involved in issues of hospital finance, became increasingly dissatisfied with the differing payment rules. [38]

Not everyone remembers this period with negative feelings. In spite of the difficulties under the 409 structure, it was also remembered as a time of high energy and dedication on the part of the Commonwealth’s health policy makers. A key hospital official remembers the Chapter 409 period as a special time in the rate setting era:

^{vi} Interview with Larry Lawrence, Exec. VP, Maryland Hospital Assn., Lutherville, 6/21/95.

"(They were) the golden days of rate setting in the late 1970s, when the Rate Setting Commission was able to attract very dedicated and competent people who were strongly committed to doing the job well."^{vii}

Health maintenance organizations, a tiny part of the market before 1980, were not affected at all by the new 409 reimbursement rules. But they were an object of attention and support from various state officials. Beginning in 1978, the state opened an HMO Project Office to encourage the development of prepaid group practice. The Rate Setting Commission led an interagency HMO Task Force to review and make recommendations concerning HMO applications for federal grants and state licensure.

In 1980, the Legislature approved Chapter 540 to tighten the cost control mechanisms contained within the Chapter 409 structure. The leadership of the Rate Setting Commission designed the structure of the new law as a way to put pressure on the business community to become involved in health policy and politics, and as a device to move the state toward adopting an all-payer rate setting system. Hospitals were permitted to increase their charges by no more than the rate of inflation in 1981 and 1982, rather than at the prior level that guaranteed their "reasonable financial requirements." Also, a Legislative and Executive Commission was established to develop further recommendations for hospital finance and access reform. [39]

The Commission disbanded without making recommendations, and several of the key interests groups (hospitals, Blue Cross, and commercial insurers) backed various pieces of rival legislation to further their own positions. Nelson Gifford, chief executive of a large manufacturer and chairman of the Mass. Business Roundtable's Health Care Task Force, organized a select group of former commission members representing the Mass. Hospital Association, Blue Cross, the Life Insurance Association of Mass., the Mass. AFL-CIO, the Mass. Medical Society, and the State Executive Office of Human Services.

^{vii} Interview with Stephen Hegarty, former CEO, Mass. Hospital Assn., Burlington, 12/21/94.

Consumer representatives were not included. Gifford used business' considerable influence over both Blue Cross and the hospitals to block consideration of their own legislative proposals and to reach agreement on an all-payer rate setting system that became known as Chapter 372. [40]

In an unusual show of interest group unity, all parties to the Coalition signed a joint letter in support of the all-payer proposal that subsequently sailed through the Legislature without opposition. The Hospital Association, fearing that the new federal DRG system would underpay large academic teaching centers, requested a Medicare waiver to allow federal participation in the new system. The waiver was granted on September 30, 1982 for a three year period. It has been suggested that officials in the Reagan Administration looked favorably upon the waiver as a means to assist Incumbent Democratic Governor Edward King (known as President Reagan's favorite Democratic governor) in his unsuccessful re-election battle with former Governor Michael Dukakis. [41]

The 372 structure contained several new and important features. First, it provided that the four major payer categories (Medicare, Medicaid, Blue Cross, and commercials) paid a set percent of hospital charges. Second, it created specific incentives to reward hospitals that reduced the intensity of ancillary services per admission. Third, it also provided strong incentives to hospitals to reduce admissions and disincentives for hospitals to increase admissions. Business supported this structure as a means to reduce the rate of growth in hospital costs, and also to ensure that commercial insurers would be able to compete effectively against Blue Cross, preventing a monopoly by the State's largest health insurance carrier. Blue Cross still retained a statutory advantage over their commercial rivals, thus ensuring their support. [42]

One other key feature that differed from the other three subject states was the treatment of HMOs, who were deliberately left outside of the rate setting structure, free to negotiate any rates of payments that they could. This minor design feature, incorporated

as part of the State's strategy to encourage HMO growth and development, would have major implications for the future of the system that were not apparent during the heated discussions in 1982.

New Jersey: The experience of the New Jersey SHARE program, which ran from 1975 until 1982 when DRGs were fully implemented, resembled the political difficulties of Massachusetts more than the steady success of Maryland. Research on the SHARE program has found that the program did contain hospital cost increases, but that it also threatened the viability of most inner city hospitals, and also led to cost shifting to commercial payers because the program only regulated Blue Cross and Medicaid. [43] Other research that compared New Jersey hospitals during the SHARE years with a group of eastern Pennsylvania hospitals found that increases in cost per admission and per day were lower in New Jersey, with most of the savings attributable to reductions in length of stay. [27] In spite of its shortcomings, later research by Hsiao and Dunn found that the successor state DRG system did no better (or worse) than the SHARE program in constraining hospital cost inflation in New Jersey. [44]

Dissatisfaction with the SHARE program centered on several factors: first, the cost shifting from Blue Cross and public payers to commercial carriers and self-pay patients; second, the worsening burden of uncompensated care carried by urban hospitals (who, unlike their suburban counterparts, could not shift costs onto their tiny base of commercial payers); and third, the belief that per case payment would provide better incentives for cost-effective care by hospitals than the per diem method used in the SHARE model. These dynamics came together with the legislative passage of Chapter 83 in 1978 that extended rate setting over all payers and hospitals, and made explicit that the cost of uncompensated care would be treated as an "allowable financial element." The Legislature, significantly, left the choice of reimbursement methodology up to the Department of Health. [46]

As mentioned in the previous section, Commissioner of Health Joanne Finley had worked at the Yale School of Public Health, and was familiar with the work of Robert Fetter and John D. Thompson in developing the case-based reimbursement method that came to be called “diagnosis related groups.” The federal government, interested in encouraging experimentation along these lines, awarded the State a \$3 million grant to design alternative hospital cost controls. The grant enabled Finley to attract high caliber personnel at higher than normal state salaries. Bruce Vladeck, who became the DoH Assistant Commissioner in 1979, negotiated complex agreements with both the federal government (assuring financial neutrality) and the New Jersey Hospital Association (assuring process rights and aid to urban hospitals) to allow the system to be implemented over three years, 1980 to 1982. [47]

Even before full implementation, 10 of the 11 senior DRG project managers had left New Jersey state government both for other career opportunities and because of the election of a Republican Governor, Thomas Kean. The impact of this change on the pioneering reimbursement system should not be underemphasized. Weiner and Sapolsky note that: “The DRG system was very complex and difficult to run. It had been initially implemented by a task force of outside specialists which had been mandated and funded separately from the existing department bureaucracy. The permanent civil servants had no great affection either for their rivals or for the system they had developed. Because of their high visibility in New Jersey, however, the task force members soon had even better career opportunities as private consultants or in Washington. By the mid 1980s, the rate setting tasks were being handed over to the civil servants. Hospitals, on the other hand, had an incentive to continually expand their expertise.” [48]

New York: As was witnessed in Massachusetts and New Jersey, the inclusion of only Blue Cross and Medicaid in early rate setting schemes led to cost shifting, instability, and the mobilization of commercial payers to protect their interests. This dynamic was most pronounced in New York where policy makers proactively “coupled” Blue Cross

and Medicaid rates in the per diem prospective payment system initiated in 1970. As a result, Blue Cross and Medicaid rates were kept artificially low, and increasingly cross-subsidized by commercial payers.

During mid to late 1970s, the system became seriously unstable because the cross subsidy from commercial payers needed to maintain the system was growing, but the base of commercial payers was not. A severe budget crisis hit New York State and City in the 1975, similar to the economic downslide affecting Massachusetts at this time. To address the budget gap, the state froze income eligibility levels and cut reimbursement rates for Medicaid. As a result, the percentage of New York's poor covered by Medicaid dropped from 79 percent in 1979 to 60 percent in 1982. [49]

A second change heightened the restrictiveness of rate setting increases, denying routine and ancillary costs exceeding a peer group mean. Because Blue Cross rates were coupled to those of Medicaid, the reimbursement rates paid by the Blue Cross plans to hospitals fell as well. The hospital industry responded by cutting their costs, running deficits, and shifting all possible costs to the unregulated commercial payers. The payment crisis led many hospitals to the brink of financial ruin, and forcing some to dip into their declining stock of endowments. By 1978, inpatient rates for commercial insurers were on average 25 percent higher than the rates for the Blue Cross plans, and the commercial plans refused to write any new policies, threatening to abandon the state. [50]

In response, the state passed Chapter 520 of the Laws of 1978, taking its first steps to regulate commercial rates, capping the Blue Cross-commercial carrier differential, and announcing plans to reduce it further over time. Importantly, the state also set up the Council on Health Care Financing that was directed to develop a new system for reimbursing hospital care in New York State. The Council enjoyed strong leadership from Republican Senator Tarky Lombardi and Democratic Assemblyman James Tallon, both of whom worked cooperatively to overhaul the state's hospital finance laws to

stabilize hospitals and to control the growth in costs. Tallon provides perspective on the situation faced by the State in that period:

“In 1978, the hospitals were frantic over a growing problem in urban hospitals in dealing with uncompensated care. If I look at the 1978 chaos, and the fact that New York’s health system has survived, and that New York has still maintained the value of trying to provide care for the medically indigent population, I’m not sure that there was a better way to get from 1978 to 1995.”^{viii}

The system they created became known as NYPHRM -- the New York Prospective Hospital Reimbursement Methodology -- pronounced “ni-frim.” It has had five legislatively created versions, each with a three year life-span. The system had the distinct challenges of: 1) controlling the growth in hospital costs without creating massive cost shifting; and 2) supporting distressed hospitals and spreading the cost of uncompensated care in an equitable and politically feasible manner. The structure of NYPHRM I, enacted in 1982 and implemented in 1983, included eight key features:

1. all payers were included;
2. payments were prospective, on a per-diem basis;
3. payments were linked to the 1981 base year;
4. payments were linked to cost of similar hospitals;
5. payment rates differed among payers, but the 25 percent differential between Blue Cross and commercial payers was reduced to 15 percent;
6. care for the poor and uninsured was financed through a system of pools;
7. Rochester’s unique payment program was exempted;
8. Regulatory authority was given to the Department of Health.

[51]

As part of the last item, a 31-person State Hospital Review and Planning Council (appointed by the Governor with the consent of the Senate) was given authority to

^{viii} Interview with James Tallon, former Assembly Majority Leader, Portland, OR, 8-6-95.

approve regulations. Also, a four member Independent Panel of Economists, appointed by the Health Commissioner, helped to formulate the yearly trend factor.

The system for charity care and bad debt reimbursement represented a major systemic change. Eight regional pools were formed throughout the state. Medicare participated in the original version with the approval of a federal waiver allowing its involvement and approved in December, 1982. The regional pools were needed to convince upstate interests that their needs would not be subsumed by the major problems faced in the New York City region. Each hospital received the same proportion of reported uncompensated care need through pool disbursements, though municipal hospitals were treated separately. The surcharge amounted to two percent of hospital revenues, or \$155 million in 1983, three percent or \$252 million in 1984, and four percent or \$364 million in 1985. [52]

Summary Comments on Growth Period: From the first period to this one, several changes in the dynamics of rate setting are apparent. Regarding the theory of economic regulation, we can observe a heightening of interest group activity and involvement, and a narrowing of interest beyond a central core of key players. Hospitals, whether supportive at birth such as in Maryland, or in opposition such as in New York, adapted quickly to become central players in the dynamics of regulatory development and assumed the role and behavior of the “cartel” in ways not observable at the birthing stage. Because all four states were moving in the direction of seeking Medicare waivers, and because hospital industry support was essential in winning waiver approval from HCFA, we can observe close collaboration between hospital officials and state regulators.

The insurance industry’s involvement shows clear development as the commercial carriers woke up in Massachusetts, New Jersey, and New York to the impact of rate setting on their business. In each state, they moved aggressively to protect themselves from a Blue Cross/public payer cost shift, a trend that mirrored the national support of

hospital rate setting advocated during this period by the Health Insurance Association of America.

While it is difficult to assert that rate setting became completely “an insider’s game” during this period, it is true that the question shifted from one of “to regulate or not” to one of “how to regulate most effectively.” The details involved in answering the latter question leave out the great numbers of legislators, citizens, and groups unfamiliar with the complexities and technicalities of health care finance. As such, we can observe a narrowing of the field of interest, a narrowing that helps move the agendas and policies of the key interest groups.

Regarding punctuated equilibrium, we can observe that, for the time being, the central policy idea -- public utility-like regulation of the hospital sector -- went unchallenged. In spite of serious instability and crisis in the hospital sector in three of the four states, there is no evidence that anyone seriously suggested dropping hospital rate setting as a policy option. Instead, the policy question was how best to expand the scope of regulatory activity. Other related questions were how to make provisions for uncompensated care in this area, how to support vulnerable institutions that cared for the medically indigent, and how to prevent damaging levels of cost shifting that were in evidence. As was true during the birthing period, there were no significant voices suggesting deregulation, decreased regulation, or market competition as alternative policy ideas. Instead, what was clearly in evidence was the establishment and refinement of a policy monopoly around the idea of all-payer, mandatory rate setting. The emergence of an alternative idea, as well as the emergence of health maintenance organizations and managed care, were yet to come.

Maturity: The following section covers the period from implementation of all-payer rate setting to the beginning of deregulation discussions in Massachusetts, New Jersey, and New York, and to the recent two years in Maryland. During this period, the

life cycle theory suggests that we should see few major changes, the evolution of a more functional structure with professional managers, less delegation, an emphasis on efficiency, and generally incremental decision making. Despite the efforts of policy makers and regulators, we will observe that the developments during this period set the stage for the rate setting deregulations that followed in Massachusetts, New Jersey, and New York. During this period, we see increased interest group competition among hospitals and the mature emergence of new players such as the HMOs.

Maryland: With the approval of the all payer Medicare waiver, the Maryland rate setting program moved into a long period (between approximately 1978 and 1994) of stability and control among a small core of interested participants. Numerous revisions and adjustments to the system were made by the HSCRC: i.e., creating a hospital screening program in 1982, establishing an Inter-hospital Cost Comparison methodology in 1983, stepping up cost control pressure on outlier hospitals through the creation of Productivity Improvement Policy in 1985, developing Objective Price Standards in 1986, implementing a Medicare screen program to identify high cost Medicare providers in 1990, and others. [53]

Health care remained a salient political issue in the State, but in areas not directly related to the control of hospital spending. In fact, in 1993, the General Assembly laid the groundwork for the expansion of the rate setting model to physician and other non-hospital services with the creation of a companion agency to the HSCRC called the Health Care Cost and Access Commission. The new agency was also charged with initiating health insurance market reforms and undertaking data collection responsibilities for non-hospital providers. In 1994, HSCRC's long-time Executive Director, John Colmers, changed positions to become head of the Cost and Access Commission, while his deputy, Robert Murray, took the helm at the HSCRC.

The major challenge facing the Maryland rate setting system during this period involved the maintenance of the Medicare waiver that many believe is a critical linchpin of

the system. Though the waiver was incorporated into federal law in 1980, it established a financial test requiring that the system not result in greater Medicare expenditures than would have occurred under the PPS system over a three-year period. Twice during the past ten years, in 1986 and again in 1990, Maryland system supporters joined together to win approval of changes to the waiver statute (Section 1814(b) of the Social Security Act). The HSCRC's fiscal year 1993 Report to the Governor relates the following information relative to the 1990 statutory changes:

"Although we have been in no immediate danger of losing the waiver, we continue to closely monitor our performance on the waiver test and continue to provide both positive and negative incentives to hospitals to improve Medicare utilization. Through your assistance, and the leadership of the Maryland Congressional Delegation, we were successful in November, 1990 in modifying the language of Section 1814(b) of the Social Security Act, which determines the ability of Maryland to continue its all-payer hospital reimbursement system. The change in the law allows for a more equitable comparison between Maryland's performance and that of the nation by taking into account savings that have been achieved from January 1, 1981 forward. Language was also incorporated into the waiver test that would allow Maryland three years to come back into compliance with the test if, in the unlikely event, we were ever to fail the rate of increase test. The most recent waiver test information indicated that payment per admission for Medicare patients nationally increased 166.78% from January 1, 1981 through March 31, 1992 compared to a 112.5% increases in Maryland over the same time period."^{ix}

One participant and observer of the system recalls discussions among interested parties concerning the rationale behind the statutory changes:

"For several years they had to go to Congress to change the base ... they said plainly that if we didn't change the base, we would lose the waiver."^x

A distinguishing characteristic of the Maryland system relative to the those of the other three states is the strong, positive relationship that has developed between the regulators

^{ix} Report to the Governor, Fiscal Year 1993: HSCRC

^x Interview with Geni Dunnells, Exec. Dir., MD. Assn. of HMOs, Annapolis, 6/2//95.

and the hospital industry. A 1992 Washington Post profile of the system included comments from hospital leaders that were unusually positive coming from a regulated industry: Johns Hopkins Hospital Director Robert Heyssel stated: "It's been good for everybody. It's certainly been effective in holding down hospital cost rises." Holy Cross Hospital President James Hamill said, "I've become a big fan." And Charles Seward of Suburban Hospital of Bethesda noted, "I don't know of anyone hurting big time because of the regulatory system." ^{xi}

Alone among the four states, Maryland set and held to tight controls on hospital price discounting by all parties, including HMOs. Discounts of no more than four percent are permitted to all insurers, but only those meeting "Substantial, Available, and Affordable Coverage" criteria: 1. open enrollment periods; 2. group conversion policies; 3. pre-existing condition limitations; 4. limited deductibles and coinsurance; and more. Currently, only a handful of HMOs and Maryland Blue Cross meet the requirements for the discount.

In spite of this tight control, HMOs have flourished in the state in the past decade. From being number 21 among the 50 states in HMO penetration in 1984, Maryland ranked number four in 1993 -- a development diametrically opposite to that predicted by many rate setting researchers in the early 1980s who thought that such regulation would inhibit HMO development and growth. Two explanations were suggested for this unexpected development. The first is that the high number of federal and state employees, with specific incentives for managed care participating, was highly attractive to managed care firms. The second explanation is that the relatively high per capita health and hospital

^{xi} Rich, S. "Cost cutting in Maryland paves the way"; Washington Post, Dec. 8, 1992

costs still provided ample room for managed care entities to make profits by reducing both hospitalizations and lengths of stay.^{xii}

Massachusetts: Beginning in this period, a clear pattern should be evident that contrasts Maryland with the other three rate setting states. In Massachusetts, New Jersey and New York, the all-payer systems had success holding down the growth in hospital costs during their first half and more of the 1980s; during the latter part of the decade and into the 1990s, the capacity for cost control collapsed for a variety of reasons that will be discussed in turn.

In Massachusetts, the system negotiated under Chapter 372 in 1982 emphasized strict cost controls, allowing hospitals medical inflation increases from the 1981 base year, minus negative adjustments for expected productivity increases. During this period, the Health Care Coalition continued to meet to address discrepancies in the new system, particularly involving treatment of bad debt and charity care, as well as the special status of Boston City Hospital, which treated about a quarter of the Commonwealth's medically indigent population.

The system was modified in 1985 in two significant ways. First, the hospital industry decided to abandon the Medicare waiver that allowed that program to operate according to the state rules. Because the waiver application had to emanate from the Massachusetts Hospital Association, their loss of support was critical. Originally, hospitals were interested in the all-payer model out of fear that a national prospective scheme for Medicare would cost them significant amounts of revenue. Instead, hospitals officials learned that the Medicare Prospective Payment System in its early phase was most generous to hospitals, especially to academic medical centers. HCFA officials also made it clear that renewal of the waiver was looked upon unfavorably and would include

^{xii} Interview with Dr. Gerard Anderson, Johns Hopkins School of Public Health, Baltimore, 6/2/95.

more onerous requirements. The legislative reauthorization (Chapter 574) of the rate setting program in Massachusetts, thus, went from "all-payer" to "three-payer wraparound" with Blue Cross, commercial payers, and Medicaid still operating according to the prior rules. [54]

The second significant change created the state's Uncompensated Care Pool to reimburse hospitals for charity care and bad debt costs. The pool was funded by a uniform surcharge on all payers, including a \$20 million addition to private sector charges to account for Medicare's exit from the all-payer system, and was collected by the hospitals. The hospitals had argued successfully -- with support from the Dukakis Administration -- that the controls on charges did not recognize legitimate uncompensated care needs. The Health Care Coalition agreed with their assessment, suggesting, however, that the pool would only be a transitional arrangement as policy makers devised a program to provide universal coverage. While the surcharge began at an initial level of approximately seven percent of charges, and \$160 million, it ballooned by 1988 to nearly 14 percent and more than \$300 million, as hospitals were able to reap significant revenues from a pool with few controls and little accountability.

Because Chapter 574 was seen as a transitional arrangement to a broad, universal coverage program and to more hospital competition, the law was given a sunset of September 30, 1987. A new public Study Commission replaced the private Health Care Coalition. The Commission ended its work in June, 1987, unable to agree upon either a universal coverage scheme or a replacement hospital financing mechanism. The hospital community began a campaign of heavy pressure to relax the financial controls of the prior regulatory program, culminating in a rally on the Boston Common in early September, 1987 with nearly 10,000 hospital workers (bused in by the hospitals) chanting "cost containment has gone too far."

The replacement statute, Chapter 23, and known as the Universal Health Care Law, was signed in April, 1988, and contained a much publicized "play or pay" employer

mandate and other coverage expansions. Less publicized were very different rules governing the continuation of hospital rate setting until September 30, 1991. Hospitals supported the new law because they were permitted a variety of means to increase significantly their charge bases, with different mechanisms for different groups of hospitals. The Chapter 23 changes gave hospitals charge increases that averaged seven percent above medical inflation for the fiscal years 1988 and 1989. The major changes incorporated in the new law seriously discouraged many of those who had been strong supporters of the rate setting program:

"The last four years were the worst era of the rate setting system in Massachusetts. It contained features that were guaranteed to be inflationary such as the percentage add-on for labor costs -- hospitals could keep whatever they could prove was spent on labor. It was directly in opposition to what we know about incentives and prospective budgeting."^{xiii}

Large business organizations, including the Massachusetts Business Roundtable, had publicly supported the new law for three reasons: first, private sector contributions to the uncompensated care pool were capped at \$300 million; second, they saw the law as a transition to a more competitive financing model; and third, their leaders had committed them to a position in support of universal coverage. Small business outrage and mobilization after enactment led these large business groups eventually to withdraw their support for the universal coverage provisions; and the cost provisions led business eventually to support full deregulation.

In addition to the discouragement over the fate of the system's cost containment features, other supporters became frustrated and annoyed with the system's growing complexity and indecipherability. Over time, only a smaller and smaller circle of inside

^{xiii} Interview with Paula Griswald, former Chairperson, Mass. Rate Setting Commission, Boston, 12/23/94.

players had any real understanding of the system's dynamics; the hospitals were considered to have a major advantage in understanding and manipulating the system to their own advantage. One of those players describes his own impressions of the actual statutes that he had carried through the legislative process:

"The statutes were incomprehensible, like Sanskrit. No one could understand them anymore, even the hospital people themselves. They were incredibly complicated -- things like gross patient service revenue plus -- you ought to include a page of it in your dissertation. They were like hieroglyphics. A lot of work for attorneys and accountants." ^{xiv}

In accord with this request, a page from Chapter 23 is included in the appendix to this study. ^{xv}

As the rate setting, charge control system was rapidly disintegrating into a non-control system, another change was creating a different kind of transformation in the Massachusetts health care market -- the rapid growth of HMOs and managed care. That part of the story is best saved for the description of the decline.

New Jersey:

"The DRG system was like a methadone program -- a guaranteed bottom line every year, and no one could understand how it worked. They reconciled money at the end of each year, and then put the reconciliations into their future base rates ... I remember sitting at one hearing. The hospitals would say: 'These are our shortfalls.' The payers would say: 'No, we disagree.' The Body would always arbitrate somewhere in the middle." ^{xvi}

As discussed in the previous section, the New Jersey SHARE program was replaced by the nation's first DRG reimbursement method because of specific problems

^{xiv} Interview with Edward Burke, former Senate Chair, Joint Committee on Health Care, Framingham, 12/16/94.

^{xv} Acts and Resolve of the Massachusetts General Court, Chapter 23, 1988

^{xvi} Interview with Dennis Marco, Vice President, NJ Blue Cross, Newark, 4/20/95.

with the prior program. Commercial insurers protested the cost shift from regulated Blue Cross and Medicaid rates; urban hospitals faced financial crisis and potential bankruptcy because of their inability to shift costs onto their small base of commercial payers, a problem worsened by tightened Medicaid budgets; and policy makers felt that the per diem SHARE model did not encourage decreases in hospital lengths of stay. The Health Commissioner's familiarity with the Yale DRG researchers provided the policy link.

Hsiao and Dunn examined hospital expenses per capita and per admission between 1971 and 1984 (pre-SHARE, SHARE, DRG) and found that SHARE had restrained the growth in hospital costs relative to the pre-SHARE period, and that the DRG program continued but did not improve on that performance. DRGs, they concluded, reduced costs per case and lengths of stay, but increased admissions thus neutralizing the reduction in costs relative to SHARE. "Prospective rate setting, DRGs included, was effective in constraining total hospital expenditures in New Jersey. There was a marked decrease in hospital cost inflation when the SHARE per diem rate regulation was introduced ... rate setting programs can be designed to achieve health care objectives beyond cost control. The New Jersey DRG regulation provided for uncompensated care and promoted the financial viability of the state's inner city hospitals." [55]

As occurred in Massachusetts and New York, the latter half of the 1980s saw the undermining and gradual disintegration of the New Jersey system. Three sets of developments worked to diminish public and interest group confidence in the system. The first was a seemingly inconsequential design feature affecting hospital bills. While hospitals were paid according to the DRGs, itemized charges for each hospital stay would also appear on each patient's bill. As one researcher noted, "(T)he DRGs, which were based on averages, were rarely equal to the total of itemized charges; and cases for which itemized charges fell below the actual payment rate were widely publicized as wasteful hospital spending. On the other hand, bills with itemized charges far in excess of the actual DRG payments did not receive public attention". [56] The Republican Speaker of

the Assembly, who is candid about his own lack of sophistication in matters of health care finance, saw this as a central weakness:

“A lot of members had received complaints from their constituents. A guy breaks his arm, and his hospital bill says it cost \$1500, but he has to pay this DRG rate of \$3000 ... This was the old \$950 toilet seat all over again.”^{xvii}

Second, while the DRG system led to the stabilization of both commercial payers and the urban hospitals, concerns were increasingly expressed about the financial integrity of the system in holding down hospital costs. Beginning in 1987 and 1988, a series of measures were implemented to alleviate a severe nursing shortage, a burgeoning AIDS epidemic, and other needs, adding more than \$500 million to system costs. A retrospective settlement and appeals process, which was designed for only a few outlier cases, became a regular activity for most hospitals. The appeals system became so unwieldy that regulators arranged in 1991 a one time mass settlement of all pending claims to the end of 1988, amounting to about one billion in upward charge adjustments. Another billion dollars worth of claims was pending from the 1989-91 period when the program was deregulated in 1992. [57] A regulator who ran the DRG program sighed in recalling the experience:

“Over 12 years, the system saved the state money, but there was a lot of catch up by the hospitals in the last five years ... The system was not prospective enough. We were collapsing under the weight of these backup appeals.”^{xviii}

^{xvii} Interview with Charles Haytaian, Speaker, New Jersey Assembly, Trenton, 4/18/95.

^{xviii} Interview with Pamela Dickson, New Jersey Department of Health, Trenton, 4/18/95.

The hospitals' success in winning their battles before the Rate Setting Commission led some early supporters of the system to conclude that they were being taken. A key labor leader recalls his own perceptions:

"DRGs, as originally conceived, was a great idea. The guy that conceived it was Bruce Vladeck. We helped to sell it through the unions as a great concept to stabilize costs. Then we had long discussions with Prudential -- they said that hospitals have gone to software companies and melded procedures into coded formulas involving 'x' numbers of dollars. They would add a complication here, an extra procedure there. It started to go crazy ... DRGs had become so corrupt, the insurance companies went to the same software companies and said, 'give us one that neutralizes them'."

^{xix}

The state's hospital charges were increasing rapidly just as the federal government began to squeeze down its own increases in Medicare rates. HCFA, which had aggressively pushed the State to create the DRG model in the late 1970s during the Carter Administration, actively discouraged such experiments during the Reagan/Bush Administrations of the 1980s, and only renewed waivers during the mid-1980s because of pressure from, among others, New Jersey's Republican Governor Thomas Kean. HCFA concluded in 1988 that the financial test for the Medicare waiver had not been met and that it would not be renewed. The DoH appealed, but HCFA would not relent, and the waiver was lost in 1989. Hospitals did not see the change as critical because the state had promised to make up the difference through the DRG payer differentials. [58]

The loss of the waiver badly exacerbated the third key ingredient feeding dissatisfaction with the system, the New Jersey Uncompensated Care Pool. While hospitals had been permitted to account for charity care and bad debt as part of their charge structures going back to the SHARE program, the New Jersey Uncompensated Care Trust Fund was established in 1985 as a means to treat all hospitals equitably. The

^{xix} Interview with Charles Marciante, President, New Jersey AFL-CIO, Trenton, 4/18/95.

surcharge to fund the pool began in 1986 at 7.8 percent, or \$366 million, with Medicare paying 47 percent of that amount because of the federal waiver. By 1991, the surcharge had risen to 19 percent of all hospital charges, totaling nearly \$1 billion, with Medicare paying nothing since the discontinuation of the waiver in 1989. [59]

In addition to the total cost, suspicions were evident among payers that hospitals were using the pool in a wasteful and inefficient way. While Massachusetts had moved to cap pool contributions and to control expenditures in 1988 and 1991, New Jersey continued to permit full reimbursement for bad debts, which in 1989 accounted for more than 80 percent of trust fund expenditures with less than 20 percent going for charity care to uninsured persons. [60] While national data demonstrated that the uninsured used 47 percent less hospital care than did the insured, the uninsured in New Jersey in 1990 used 30 percent *more* hospital care than the insured. [61] "The strong perception, not wholly untrue, was that the hospitals and middle class together were ripping off the system." [62]

With New Jersey Blue Cross facing financial losses of \$300 million in 1991, and the New Jersey Business and Industry Association and other groups demanding tighter controls and accountability from the pool, the stage was set for dramatic changes. A lawsuit filed by the state's Carpenters' Union in 1991 began the transformation process.

New York:

"If one looks at the whole NYPHRM era, from 1983 to 1995, it would be typified as a period of unique stability in the system where there was no threatening loss of access for an uninsured population that tended to grow ... Most institutions that were shut out of capital markets for more than a decade were able to reconstruct themselves under NYPHRM..."^{xx}

^{xx} Interview with Ray Sweeney, former NY Dept. of Health, now HANYS, Albany, 7/21/95.

"It's father knows best" ^{xxi}

"It's a habit" ^{xxii}

"It's simply a dinosaur" ^{xxiii}

Not coincidentally, the NYPHRM era coincided with a unique long term era of Democratic dominance and political stability in New York State. Though the system had its roots in the Republican liberalism of Nelson Rockefeller, it came to its zenith during the successive administrations of Democrats Hugh Carey and Mario Cuomo between 1975 and 1994. Long term political peace enabled the New York Department of Health to avoid the rapid staff turnover and discontinuities that plagued rate setting programs in New Jersey and Massachusetts. The hospital associations had far more sophistication and depth than their counterparts in other states. Bipartisan leadership in the State Senate and the State Assembly created a rare convergence of opinion that rate regulation was a legitimate and proper activity for state government. This attitude also was accompanied by a deep mistrust of for-profit entities -- indeed, New York law does not permit for profit ownership of acute hospitals. [63]

These factors helped the state to enact five distinct versions of NYPHRM since 1982. The original version, implemented in 1983, was shepherded by Lombardi and Tallon with the support of hospital associations, Blue Cross, commercial payers, labor, and the Administration. The structure included eight regional pools to provide reimbursement for bad debt and charity care. The first system was all-payer, operated with a waiver from the federal government to permit Medicare participation.

^{xxi} Interview with John Rossman, Hospital Assn. of New York State, Albany, 6/29/95.

^{xxii} Interview with Richard Kirsch, Executive Director, New York Citizen Action, Albany, 6/29/95.

^{xxiii} Interview with Edward Rinefurt, Vice President, Business Council of New York State, Albany, 6/30/95.

Under NYPHRM II, enacted in 1985, the state dropped the federal waiver at the insistence of the hospital associations, who realized \$200 million in additional revenue under the PPS system which was designed to be especially generous to academic medical centers, of which New York had many. [64] Both NYPHRMs I and II were per diem reimbursement models.

NYPHRM III's central innovation in 1988 was the switch from per diem to per case reimbursement. DoH officials had wanted to move to per case in 1985, but did not have enough time to make the transition; they were troubled by the long length of stays in New York hospitals, the highest in the nation, and felt that per case payment would address this problem. It did not, though officials believe that new public health crises overshadowed their successes in reducing lengths of stay. The change in reimbursement methods was accompanied by a renewed vigor on the part of DoH regulators to hold down the growth in costs at the same time that the AIDS and crack epidemics were creating major new demands on hospital providers beyond that experienced by their counterparts in other states. Tightening Medicare reimbursements created added pressures on a system heavily dependent on graduate medical education reimbursements. These pressures resulted in operating losses to hospitals of more than a billion dollars in 1988, creating the most significant hospital financial crisis since the mid-1970s. [65]

While NYPHRM IV, enacted in 1990, kept the structure of NYPHRM III intact, the Legislature responded to the reports of serious financial difficulties among hospitals by adding back into the system new funding in the amount of approximately \$400 million per year, in the form of special adjustments for hospital labor costs. The rates continued to be based on the actual cost experience of each hospital in its 1981 base year -- "a lifetime ago in terms of the development of health services." [66]

Beginning with version III and greatly expanding into versions IV and V, policy makers began to use the NYPHRM system -- and the uncompensated care pools, in particular -- as a device to create, finance and expand a variety of health care initiatives

that were unrelated to hospital finance controls. These initiatives included: 1) health insurance expansions including the Child Health Plus program to provide primary and preventive coverage for children; 2) primary care service expansions to the medically indigent and their providers; 3) community needs assessments by hospitals; 4) rural health networks; 5) education and training support for primary care practitioners; and more. [67] NYPHRM V, enacted in 1993, continued the patterns set in IV of providing additional financial support to distressed hospitals, and furthered the expansions in unrelated services funded via the uncompensated care pools.

Three broad areas deserve attention in forming summary judgments on the NYPHRM experience. First, the system's complexity is overwhelming: "(W)hatever else one might say of NYPHRM, as it has evolved over the past decade, it is certainly very complicated." [68] This complexity has policy implications that also apply to the other subject states. The problem was well summarized in a RAND policy analysis of the New York system: "All parties in New York would stipulate that the system is impossibly complex, with the formulae and methodology changing and growing more intricate each year. This complexity is the subject of considerable black humor within the state, but it has very serious policy and financial consequences for two reasons. First, financial incentives don't work if decision-makers don't understand them. The system reportedly has become so elaborate and arcane that many hospital CEOs and other leaders don't understand how it works at all. Second, financial incentives don't work when they are internally inconsistent ... the attention of the regulatees becomes riveted on how to change or game the system. Each two years, there is what one participant interviewed terms an 'exercise in war games' in which the players converse to see who will get how much money from the system." [69]

The second set of observations involves the weak financial performance of the system. It is clear that goals other than pure cost containment were part of the rationale for NYPHRM. These goals included access, financial stability for hospitals, and more. As

a result, near the end of its rate setting experience, New York's hospital costs are as much an outlier among the 50 states as they were in 1970. Since 1982, total hospital costs in New York have increased 12 percent more than the nation as a whole. Additionally, New York hospitals continue to be in the weakest financial position of hospitals in any state in the nation, in spite of the fact that New York hospitals reaped more financial rewards under Medicare than those of any other state. "Periods of stringent cost containment, resulting in serious financial losses for hospitals, are followed in an almost oscillating fashion by years in which more money is pumped into the system, in part to compensate for prior year losses ... New York State possesses an extraordinary armamentarium for the regulation of inpatient hospital services; but like the drunk who looks for his keys under the lamp post because that's where the light is, the state's tools may be increasingly less well suited for the task at hand." [70]

A key legislator involved in many NYPHRM discussions and versions recognizes the turnaround in the system's financial directions:

"The system was originally thought of as a way to keep a ceiling on costs, which is basically why the business community originally supported it. In recent years, it has in many ways served to keep a floor on costs and to keep up revenues to hospitals which is partly why I have supported it and why the business community has done an about face on it." ^{xxiv}

The final observations involve the limited ability of the system to provide access for the medically indigent. Thorpe examined the performance of the regional uncompensated care pools and found them to be "a leaky bucket," from which \$10 in pool revenue produced about \$4 in additional care for uninsured patients between 1982 and 1985. While finding that the pools resulted in increased hospital admissions, hospital days, and outpatient days for the uninsured: "(I)f the goal of such programs is to earmark

^{xxiv} Interview with Richard Gottfried, Chairman, NY Assembly Health Committee, New York City, 7/20/95.

payments to the uninsured, methods other than the New York system should be employed.” [71]

The increasing use of uncompensated care funds to finance a range of non-hospital programs and initiatives has been a means to promote valued health initiatives without the need to find appropriations in the regular state budget. But increasingly, debates over NYPHRM became fights over distribution of the residual pieces of the uncompensated care pool funds. “It is not clear that the NYPHRM approach to funding nonhospital activities is good public policy.” [72] Nonetheless, it has become a central part of the New York health financing debate:

“The rate setting law became the mainframe that a lot of other health financing pieces got attached to that may or may not add to inpatient reimbursement ... lots of bells and whistles.”^{xxv}

Summary comments on the Maturity Stage: It is during this stage that the sharpest differences emerge between Maryland and the other three subject states. Relative to the theory of economic regulation, we can observe a plethora of interest group activity in the states, but not activity that could be characterized as that of a cartel. We can also see that hospitals had their periods of stringent financial pressure and their periods of fiscal relief. In Maryland and New Jersey, the cartel theory would find its greatest support. In Maryland, a tight relationship that dates to the beginning of the system continued between regulators and hospitals, but this relationship was supported by positive financial indicators showing that the rate setting system was achieving its basic cost control objectives. In New Jersey, the hospitals initially fought the DRG system, but later supported it as an alternative to the PPS model. In that state, regulators had the greatest difficulty in controlling their system.

^{xxv} Interview with Gerry Billings, Exec. Dir., State Communities Aid Association, Albany, 6/30/95.

In Massachusetts and New York, hospitals had their financial limits loosened considerably, but only after documented financial problems and the exertion of strong external political pressures. Other parties, including business, labor, insurers, and legislators continued to play significant roles in system direction -- more resembling the "policy monopoly" structure characterized in the punctuated equilibrium model, where a small core of inside players determines policy moves.

Otherwise, policy ideas were not very much in evidence in any of the four states during this period, with the exception of the "ideas" that developed inside the New York uncompensated care pools. The challenge during this period seemed to be how to make the systems work, and how to balance the seemingly contradictory goals of cost containment, access for the medically indigent, financial stability for hospitals, and market stability for insurers. During this period, national policy analysts began a fervent debate on the merits of "regulation versus competition" in health care cost control, with state hospital rate setting often a key example for both sides. Nonetheless, none of that debate was observable in any of the four subject states prior to the beginning of the deregulation experience in Massachusetts in 1991.

Decline: The key features of this stage in the life cycle model include little innovation, no particular strategy, risk taking abhorrence, outdated products, and shrinking markets. In the disintegration of rate setting in three of our subject states, we can see traces of all of these dynamics.

In Massachusetts, New Jersey and New York, a strikingly similar pattern exists in the circumstances leading up to and accompanying rate setting deregulation in the first two, and the impending deregulation in the third. These common circumstances include: 1) a regulatory collision with managed care; 2) a link to significant in-state political changes; 3) a growing incomprehensibility factor and blatant regulatory failure; 4) a vastly changing interest group landscape; and 5) an anticlimactic legislative process leading to

rate setting deregulation. We will review all five of these factors in framing our discussion of the deregulation experience in the three states. We will use these same categories in the subsequent section to describe the reasons for Maryland's avoidance -- to date -- of this experience.

Massachusetts:

Managed Care: The overt allowance of HMO-hospital discounting in the Massachusetts rate setting system was only one of a number of factors that fueled the large growth in HMO penetration during the 1980s, but clearly played an important role. With health insurance costs among the highest in the nation, businesses and labor anxiously sought lower cost alternatives as health premiums soared during the 1980s. While commercial indemnity carriers were required to pay 100 percent of hospital charges, and Blue Cross had to pay 92.5 percent, booming HMOs such as the Harvard Community Health Plan were able to pay hospitals at discounted rates of 20 percent and higher, giving them important leverage in the health insurance market. Two participants recall the changing dynamic:

"Rate setting started out as a form of charge control, but over time charges became less and less relevant because big third party payers were establishing their own rates through negotiations. There were fewer and fewer charge payers actually left ... Over time, the concept of the consumer changes dramatically. Actual consumers became very large payers and developed organizations of payers." ^{xxvi}

"By 1991, we were well on our way to having the most managed care penetration of any state. Everyone could see it coming fast. That more than any other factor changed everyone's historical position on rate regulation." ^{xxvii}

^{xxvi} Interview with Bruce Bullen, Commissioner, Division of Medical Assistance, Boston, 1/4/95.

^{xxvii} Interview with Steven Tringale, former VP, Mass. Blue Cross & Blue Shield, Boston, 12/21/94.

By the late 1980s, Blue Cross of Massachusetts was facing a severe financial crisis, with some analysts predicting potential insolvency in the near future as its market share plummeted. Blue Cross' 7.5 percent discount became less an advantage and more a burden as their market share dropped from 60 to 35 percent of the privately insured market between 1985 and 1990 and as HMOs negotiated significantly better deals. [73]

While private sector pressures were building, state policy makers also felt a governmental interest in changing directions. As we saw in the "Birth" section, the role of Medicaid in the 1975 fiscal crisis was a principal dynamic in the original decision to establish mandatory rate setting. In 1989, the Commonwealth was moving rapidly into its worst economic recession since the 1930s, suffering sharp reductions in tax revenues, and Medicaid budget increases of more than 20 percent annually. In the spring of 1989, Senator Patricia McGovern officially labeled the Medicaid program as the state budget's premiere "budget buster."^{xxviii} Also in the spring of 1990, the House Committee on Ways and Means recommended "that all Medicaid beneficiaries be enrolled in some type of managed care program by January, 1992."^{xxix} The recommendation was signed into law that year. Though the program was not fully implemented until 1993, it initiated a process by which Medicaid and other state officials began to see the end of mandatory rate setting as being in their own interest. The State's Medicaid Director describes his own process in turning against rate setting:

"We really didn't have control over what we were paying. The hospitals told us what to pay by setting a fictitious charge that nobody really paid and we paid a percent of that charge. We had a different 'payment on account factor' for every hospital, and they would manipulate their charges to generate more or less revenue from Medicaid depending on what their overall revenue target was ... The payers had no way to know whether the

^{xxviii} FY91 proposed fiscal budget, Senate Committee on Ways and Means

^{xxix} FY91 proposed budget, House Committee on Ways and Means

hospital was going to gouge them or not. Deregulation was a shift of control to let the payers set the terms." ^{xxx}

Political Change: A critical factor leading to the Massachusetts deregulation was the election in November, 1990 of Republican William Weld as Governor who replaced Democrat Michael Dukakis. His election was also accompanied by significant Republican gains in the State Senate that enabled Weld to sustain his vetoes -- an important point of leverage for him in negotiating with the Democratic controlled House and Senate.

Though the fate of rate setting was not an issue in the gubernatorial race that year, primary or general, Weld brought to his Administration an admiration for free markets in all sectors. Indeed, his one specific quote on health care financing made during the campaign was that "profit should not be a dirty word in health care." Just as important, Weld brought in Charles Baker as his key health policy advisor. Baker had been director of the Pioneer Institute, a conservative Massachusetts-based think tank, and had been an outspoken critic of the 1988 Universal Health Care Law. While his and Weld's orientation were clear, the initial direction to take in the face of a September, 1991 sunset of the state's rate setting law was not certain:

"I met with Weld during the transition and I said to him, 'Do you want to delay Chapter 23 for a year? It would be easy to do.' He said, 'No. You should be thinking a lot between January and February about where people are, and what's important to them, because we really want to fix this right after we get the budget done.' I followed up with Paul Cellucci (Lt. Gov.) and he agreed. So at least on filing a bill, they were on board before they even took office." ^{xxxii}

^{xxx} Interview with Bruce Bullen, Commissioner, MA Division of Medical Assistance, Boston, 1/4/95.

^{xxxii} Interview with Charles Baker, then Undersecretary of Health and Human Services, Boston, 12/27/94.

Virtually all Massachusetts interviewees identified Governor Weld's election as a pivotal event, and Weld, Charles Baker, or the Weld Administration as key players in the drive to deregulation:

"Charlie was the most aggressive free marketeer in government and in the debate. That was the single biggest change ... Also evident was a style change. We had gone through a decade of consensus building with a few groups going back to 1981. It's fair to say that Baker and the Governor's style was not to soften their position by consensus. The model was directive, leadership -- this is where we are. The light bulb went on that the ability of groups to tug at each other was limited. He became the center of gravity." ^{xxxii}

Incomprehensibility and Regulatory Failure: Aside from the direct interests of key players, both inside and outside of government, the complexity of the system, along with the inability to estimate its true effects on all parties played an important role in disaffecting key players:

"It was growing harder to gauge the true financial health of a number of the major participants, whether payers or provider because everybody was carrying lots of potential liabilities on both sides associated with the retrospective settlement process. That was certainly true for Medicaid which ended up carrying very big liabilities down the road associated with ultimate calculations that took years to get to the bottom of ... In most people's minds, a deregulated system would be less retrospective." ^{xxxiii}

While fingers could be pointed in many directions to account for the rate setting system's problems, what could not be denied was that the system was failing to hold down large hospital charge increases. In fact, the system provided so much room for hospitals to raise their charges that many hospitals began to "bank" charge authority in order to remain competitive in the increasingly price sensitive managed care environment. In spite

^{xxxii} Interview with Steven Tringale, former Vice President, Massachusetts Blue Cross, Boston, 12/21/94.

^{xxxiii} Interview with Charles Baker, then Undersecretary of Health and Human Services, Boston, 12/27/94.

of these increases, the hospital community became factionalized in the quest for specific regulatory benefits for distinct groupings of hospitals. One group called itself the “low cost hospitals,” another the “efficiency hospitals,” another the “sole community providers,” and still others such as the Council of Boston Teaching Hospitals, and the public institutions. Each grouping had its own stable of consultants, financial analysts, lobbyists, and legislative proposals to tweak the regulatory system toward its own advantage. [74]

Fatigue with the pressures and controversies of a system that required significant exertion for questionable gain played a role in encouraging parties inside and outside of government to look at other options:

"Nelson (Gifford) tried to put together an inside game that worked for the first system under 372, and a little bit under 574, but then everyone got into the game and it became a political football. It broke apart because regulators can't get the price right no matter what the system is because they're always trailing the market."^{xxxiv}

The Changing Interest Group Landscape: The combined weight of dissatisfaction within and without government, from hospitals, insurers -- especially Blue Cross, business, labor, and legislative and executive branch officials worked together to bring down the system. As one key participant sums up:

"The system was like a sand castle. A lot of water was getting at it, undermining its basic structure."^{xxxv}

Yet despite the number of major interests who saw the system becoming contrary to their interests, groups were not clear on the exact steps that they wished the State to take in moving away from rate setting. The Massachusetts Hospital Association voted in

^{xxxiv} Interview with Robert Hughes, Exec. Dir., Mass. Assn. of HMOs, Boston, 12/15/94.

^{xxxv} Interview with Edward Burke, former Senate Chair, Joint Committee on Health Care, Framingham, 12/16/94.

December, 1990 to support continued regulation along the lines of the Maryland system, and had difficulty achieving consensus during 1991 as the deregulation effort gained momentum. Large academic medical centers, seeing the deregulated market as working in their favor, actively promoted full deregulation; but the state association did not formally back deregulation until September, 1991 when the direction was already clear.

Though business groups paid homage to free market notions, they feared the financial risks of immediate deregulation and thus advocated a three year phase out of the system, and the establishment of global hospital budget caps in their place. Labor feared a sharp spike in prices following deregulation and advocated a go slow approach, though their primary attention was on other non-health legislative matters. The insurers paid primary attention to the consecutive debate concerning small group insurance market reforms. Only consumer groups and some of their supporters in academia vigorously advocated continued rate regulation.

Anticlimax: The interest group uncertainty was reflected in the legislative process. The original Weld legislation, House Bill 5900, provided for a three year sunset period between 1992 and 1995, before the complete elimination of rate setting. The Legislature's Joint Health Care Committee reported their version, H.6100, in September that provided for a transitional period of one year, but also added a new system of ill-defined global budget caps to replace the overt rate setting controls. These versions reflected uncertainty about the pacing of deregulation more than uncertainty with the deregulation decision itself. Edward Burke, Senate Chair of the Health Committee, commented at one public hearing, "I favor putting the scorpions in the same bottle and letting them fight it out."^{xxcvi}

^{xxcvi} "Democrats Follow Weld on Hospital Bill"; Boston Globe; 9-22-91

Observers agree that the House Committee on Ways and Means made the critical decision to move toward immediate deregulation, with only a loose system of charge controls for one year that most agreed would constrict no hospital in adjusting its charges. The decision for the more aggressive deregulation stance was made by the House Chairman, Thomas Finneran, a conservative, market oriented Democrat:

"Charlie Baker sent us a bill that spoke to deregulation but they didn't want to climb over the fence immediately ... I can recall working principally with (Ways and Means budget director) Joe Trainor, and for the life of us, we couldn't quite get it. We couldn't reconcile the public and explicit embrace of a free market, and yet being just a little timid to say it and do it. Our fear was that if you let the old system hang around for a year or two, you were not really preparing people for what Carmen (Buell, House Health Comm. Chair) and I thought was appropriate." ^{xxxvii}

In the House of Representatives, the Ways and Means version was approved by an overwhelming margin of 119 to 27 on November 19, 1991. An alternative proposal to move the state toward a single payer financing model was defeated by a vote of 120 to 29. ^{xxxviii} The State Senate took up the House approved version with even less controversy, approving its modified version of the financing law on December 12, 1991 on a voice vote.

A committee of conference was established to iron out numerous language and technical differences between the two versions, especially sections pertaining to access and small group insurance reform. The basic deregulatory thrust of the legislation was not an issue in conference. The final report was approved in the House and Senate on December 21, 1991 and signed by Governor Weld as Chapter 495 of the Acts of 1991 before the start of the new year. After 16 years of controversy and debate, after a variety of

^{xxxvii} Interview with Thomas Finneran, Chairman, House Committee on Ways & Means, Boston, 1/21/95.

^{xxxviii} The single payer plan was offered by the author.

successive versions, mandatory prospective rate setting went out, not with a bang, but a whimper.

New Jersey:

On May 27, 1992, Judge Alfred M. Wolin of the Federal District Court in Newark ruled that the federal Employee Retirement Income Security Act (ERISA) preempted some key provisions of the New Jersey rate setting law, including the shifting of costs to pay for indigent medical care, bad debt and Medicare funding shortfalls.^{xxxix} The suit had been brought in 1991 by a group of building trades unions that had Taft Hartley self-insured plans. While the ruling called for either elimination of or major structural changes to the New Jersey Uncompensated Care Trust Fund, nothing in the decision required any changes to the New Jersey DRG payment system. And even though Judge Wolin's decision was immediately appealed by the State's Attorney General, the ruling led to a rapid consensus for the elimination of rate setting, and the preservation of the Pool under a different financing formula.

Managed Care: As noted earlier in this chapter, New Jersey was the only one of our four subject states to have HMO penetration consistently below the national average during the 1980s. As such, the collision between managed care and rate setting resembled more a fender bender than the major crash experienced in Massachusetts and New York. The other three subject states attempted to have clear cut rules relative to HMO discounting: Massachusetts and New York permitted discounting below the statutory charge levels, and Maryland did not allow discounting except within severely constricted authority. In New Jersey, the rate setting statute nominally did not permit any discounts beyond the established payer differentials among Blue Cross, commercial payers, and

^{xxxix} United Wires, Metal and Machinery v. Morristown Memorial Hospital, 793 F. Supp. 524 (DNJ 1992)

public payers. But most interview subjects were aware the discounting was widespread in the State's relatively narrow managed care community. DoH officials were aware of the practice:

"There were limits to how far (discounting) could go on the books. Off the books HMOs were negotiating with hospitals not as part of the DRG system ... DoH set the rates that hospitals have to charge, but we didn't set the rates that payers had to pay, and nothing in our authority permitted us to stop it. It started to become an issue in the very late 1980s. We had internal discussions about the adverse consequences because it took away our power to equalize."^{xl}

Political Change: In 1990, New Jersey state government faced a severe fiscal crisis as part of the national recession. Democratic Governor James Florio, who promised no new taxes as part of his electoral campaign in 1989, convinced the Legislature to approve major income and sales tax increases in 1990; voter dissatisfaction with the hike was in evidence in November, 1990 when then little known Christine Todd Whitman narrowly lost to incumbent US Senator Bill Bradley by only two percent of the vote. In November, 1991 Republicans won control of both the Senate and the Assembly from the Democrats in a direct rebuff to Florio. The change in political control of the Legislature had the same sea change effect on the state's political culture that the election of William Weld as Governor had in the Commonwealth of Massachusetts.

The new Speaker of the Assembly had wanted since the early 1980s to eliminate the DRG system:

"I came into office in 1981. I tried to undo the DRG system in 1984 and 1985, but couldn't get the votes, so we let it ride. But even then, we did not believe that the DRG system was going to work ... When we had the opportunity -- and Florio deserves a lot of credit; we were talking to him on a regular basis -- we said the DRG program has to go."^{xli}

^{xl} Interview with Pamela Dickson, NJ Department of Health, Trenton, 4/18/95.

^{xli} Interview with Charles Haytaian, Speaker, New Jersey Assembly, Trenton, 4/18/95.

Equally clear is that the Democrats in the Legislature were not ready to part with the rate setting system. When the final deregulation and Uncompensated Care Trust Fund legislation cleared both chambers on November 30, 1992, it did so without a single Democratic vote. The former Senate Health Committee chair describes what would have happened had the Republicans not taken control:

“I realized that the system was in trouble in 1988-89. If it worked correctly, the system would have been good. But it was a disaster with the public because constituents would ask us to explain why they were charged \$6000 for a hospital stay while their bill said it only cost the hospital \$3000. How do you explain that? Once the Republicans took over the majority, we knew that they would try to do it. If they hadn’t taken over, the DRG system would have been changed. There was no question but that the system was going to change dramatically if we had stayed in power. Since we didn’t stay, we didn’t have the opportunity to do our changes.”^{xlii}

Incomprehensibility/Regulatory Failure: The severe stresses on the regulatory system have already been described in the previous section, including the problems with DRG and hospital charges appearing on bills together. The weight of the regulatory morass appeared to be accelerating. By 1991, the Rate Setting Commission’s special appeals process, designed to respond to extraordinary cost increases at individual hospitals, was handling as many as 2,000 annual rate appeals from the state’s 85 general hospitals, some for items as low as \$35. [75] During the latter half of the 1980s, the system’s ability to control hospital costs has deteriorated badly; while total hospital revenue per capita rose 72 percent nationally between 1986 and 1991, it rose 100 percent in New Jersey, and compared with 64 percent in Pennsylvania and 86 percent in New York. [76]

^{xlii} Interview with Sen. Richard Codey, former Senate Health Committee Chair, West Orange, 4/19/95.

The Interest Group Landscape: The interest groups responded to Judge Wolin's ruling quickly by forming the New Jersey Health Care Reform Coalition that included hospital, insurer, labor, business, and physician organizations. Called together by the New Jersey Hospital Association who wanted to discuss how to salvage the Uncompensated Care Pool, the other interests in the room immediately placed the fate of the rate setting system on the table. It became clear that the prior support of prospective hospital rate setting by business, labor, and insurer groups no longer existed. The price of support from the non-hospital groups to fix the problems with uncompensated care was an agreement by the hospitals to deregulate the DRG payment system.

Also emerging from the process was a serious rupture within the NJHA between urban and academic medical centers on one side and suburban community hospitals on the other. The former group saw the continuation of rate setting as critical to their own economic survival, remembering the days of serious financial instability experienced during the 1970s; during the legislative process, this group officially split from NJHA forming the Urban Hospital Coalition. The community hospitals ultimately sided with the NJ Health Care Reform Coalition, seeing the demise of mandatory rate setting as being in their own financial self interest.

The movement by business to support deregulation was not a long held position. As recently as March 5, 1992, New Jersey Business and Industry Association President Bruce Coe gave the following testimony at a legislative oversight hearing:

"...if you conclude that regulation is better, and we're studying that very point -- by the way, we don't have a conclusion. We're studying all the cost data on regulated versus non-regulated states ... I'm not sure where we're going to come out on regulation versus lack of regulation. My present guess -- and it's about 51 to 49 -- is we may conclude that deregulation is better."

By the time of Judge Wolin's ruling, the business group had decided to support deregulation, but over an indeterminate time period.

In September, the Coalition -- which deliberately excluded Administration and Legislative participation -- announced its proposal for rate setting deregulation over a three year period, and refinancing of the Uncompensated Care Trust Fund to \$600 million by reinstituting the one cent increase in the State's sales tax that had been approved by the Democratic-controlled legislature in 1990 and repealed by the Republican-controlled legislature in 1992. Their plan did not receive a respectful hearing:

"The New Jersey Coalition was not helpful at all. They would just have a few press conferences. We threw their proposals right out. I had just decreased the sales tax by a penny. The Legislature and the Governor had said no tax hike or their proposal would be rejected out of hand. They responded to union pressure to include it." ^{xliii}

When the compromise legislation agreed to by the Governor and the Legislative Leadership was unveiled -- deregulating rate setting with one year of backstop charge controls, and refinancing the UCTF by diverting \$1.6 billion over three years from the State's Unemployment Insurance Trust Fund -- a deep fissure split the AFL-CIO from the Coalition. The labor movement fought hard and unsuccessfully to defeat the fund diversion; the urban and academic hospitals fought unsuccessfully to defeat rate setting deregulation. The difference was that serious attention was paid to the concerns and opposition of labor; little concern or interest was expressed about the need to salvage the DRG system.

Anticlimax: To address Judge Wolin's ruling, the State could have ended the pool and kept rate setting; alternatively, they could have modified the pool and kept or modified the DRG system. Instead, state policy makers chose to eliminate rate setting and refinance the UCTF.

^{xliii} Interview with Charles Haytaian, Speaker, New Jersey Assembly, Trenton, 4/18/95.

The likely direction was evident from the day of Judge Wolin's ruling. Governor Florio commented: "The court's decision today, while it needs to be reviewed in detail, would appear to finally serve notice on the Legislature that it must face up to this important issue." He said the current system "is an unwieldy system of DRG averages, hospital markups, Medicare surcharges, and appeals. It is part of a health care system that is seriously flawed and that must be changed."^{xliv} In an interview for this study, Governor Florio placed the court's decision in context:

"The court decision was the precipitating event. But it was the desire to reduce health costs that promoted changes in rate setting ... We had the sense that the initial cost efficiencies from DRGs had already come and were now dissipating because people had learned to game the system."^{xlv}

Of principal concern in May and June to state policy makers was less the fate of rate setting than securing the stability of the uncompensated care pool which, beginning in 1991, had become the engine from which the State received major disproportionate share hospital payments from the federal government. In late June, with the approval of Judge Wolin, the state extended the life of the UCTF until November 30 to buy time to arrange a new financing vehicle. Republican Senate Health Chairman Louis Bassano indicated that this was one area where both parties were compelled to work together: "Failure to act jeopardizes more than \$1.2 billion in federal money available to the state for hospital reimbursement."^{xlvi}

In November, Florio and legislative leaders announced their agreement to tap the unemployment insurance fund for \$500 million per year for three years, along with an additional \$100 million in the first year to aid hospitals with large Medicare loads.

^{xliv} Newark Star Ledger, May 28, 1992

^{xlv} Interview with Former Governor James Florio, New Brunswick, 4/17/95.

^{xlvi} New York Times, June 26, 1992

Prospective rate setting and DRGs were ended, with hospital revenue caps in place for a one year transition. Statutory requirements guaranteeing “efficient hospitals” their “full financial elements” dating back to 1978 were repealed. Two accompanying bills reformed the market for small group and non-group insurance products. Governor Florio made it clear that the latter two bills were his personal priorities in attempting to reform the state’s health system and to care for a growing number of uninsured residents.

The bills passed in both Chambers on November 30, 1992. The deregulation/UCTF bill passed the Assembly by a 48-23 vote, and passed the Senate by a 21-18 vote, with all Democrats in both chambers voting no. But it was the dispute over the funding of the UCTF that engendered vociferous opposition. Except for the urban hospital coalition, there were no significant voices arguing for the continuation of rate setting. When the legislative battle was over, Sr. Jane Frances Brady, President of St. Joseph’s Hospital and leader of the Urban Hospital Coalition commented:

“There’s no question that the (rate setting) system put us on our feet. It gave us the opportunity to build our programs and to go ahead with an expansion that we badly needed ... Arguably, the judge’s decision required a new financing system to repeal the surcharges, but not the dismantling of the whole rate setting plan. But the approach had grown so unpopular that there was little support for keeping it.”^{xlvii}

The ultimate irony of the New Jersey rate setting deregulation came on May 14, 1993, nearly one year after Judge Wolin’s ruling triggered the hospital financing crisis. On that day, a Federal Appellate Court reversed Judge Wolin’s ruling, upholding the State’s appeal. Also, in April, 1995, the US Supreme Court issued a unanimous opinion upholding the legality of broad based surcharges in a case challenging New York’s rate setting system. One other noteworthy post-deregulation development: in November,

^{xlvii} New York Times, December 6, 1992

1993, Gov. James Florio was defeated in his bid for re-election by Republican Christine Todd Whitman, thus completing the deep turnaround in New Jersey's political culture.

New York:

Unlike Massachusetts and New Jersey, New York still maintains its rate setting system as of the writing of this study. But unlike Maryland, it is reasonable to predict that by the end of 1996, the state will be on the road to deregulation of its rate setting structure that has persisted since 1970. The same indicators used to describe the Massachusetts and New Jersey experiences also helps to frame the situation in New York.

The Managed Care Collision: Prior to 1985, for profit HMOs were considered illegal in New York State under the same statute (Article 28 of the Public Health Law) that prevented for profits from owning acute care hospitals. Under the threat of litigation by investor owned HMOs, the Legislature explicitly permitted for profit HMOs to operate in New York. There is disagreement among interviewees as to whether HMOs were permitted to discount under the NYPHRM I and II per diem arrangements, but there is no dispute that little of it -- if any -- was going on prior to 1988. [77] In that year, the case-based NYPHRM III statute explicitly permitted HMOs to make negotiated rate agreements with hospitals, subject to the approval of the Commissioner of Health who was required to determine that the arrangements "will result in lower costs to the general hospital and payments approximate to costs".^{xlviii}

The DoH official in charge of rate setting remembers the review process well:

"The HMOs would send us the proposed contracts for review. One time, I got one in the mail from a hospital, with a little side note saying, 'I'm sure that you're going to disapprove this contract because it doesn't meet your test.' I wrote back saying it must meet the test or you wouldn't have

^{xlviii} Chapter 2, Laws of 1988, Section 2807-c, 2(b)(i)

signed it. I said, don't use the state as the heavy when you can't negotiate this yourself ... In general, we treated the parties like consenting adults." ^{xlix}

Since 1988, the HMO penetration rate has grown rapidly, particularly among investor owned HMOs, and the level of negotiated discounting between managed care groups and hospitals is reported to be high by all knowledgeable observers. In this context, the regional Blue Cross plans, as happened in Massachusetts, find themselves in a distinct disadvantage tied to a statutory discount off charges that is much less than HMOs are winning in the market. The continuing financial instability of some of the Blue Cross plans creates a special urgency to the need to create a more level playing field.

Also similar to Massachusetts, New York policy makers are now aggressively moving Medicaid recipients into managed care program. In writing the fiscal year 1996 budget in June, 1995, Administration officials were successful in severing the 20 year link that existed between Medicaid and Blue Cross/NYPHRM charges, freezing the trim factor for the public program. A longtime participant and observer regards this move as a watershed:

"It's now just private insurance -- meaning Blue Cross and whoever buys commercial indemnity insurance -- that is part of the system. So on the price setting side, that part of NYPHRM is diminishing and there is little opportunity to move back. The question is how fast do you want it to go away."¹

The New York Assembly's Health Chair also recognizes the managed care evolution as critical in understanding the current prospects for NYPHRM:

"The key block pulled out from under the system and leading to its collapse has been the HMO negotiated rate provision accompanied by their enormous increase in penetration in the State ... They have rapidly grown from being a footnote to being the dominant player in the field, and

^{xlix} Interview with Ray Sweeney, former DoH, now HANYS, Albany, 7/21/95.

¹ Interview with James Tallon, former Assembly Majority Leader and Health Chair, Portland, OR, 8-6-95.

now hospitals find themselves in a situation where most of their customers pay a negotiated rate designed to barely cover their costs.”^{li}

Political Change: The decades of political stability that characterized New York came to an abrupt end in November, 1994 when Democratic Governor Mario Cuomo was defeated in his bid for reelection by Republican State Senator George Pataki. Unlike the most recent Republic Governor, Nelson Rockefeller, the new Governor ran on themes of limited government, no new taxes, and deregulation. While NYPHRM’s fate was not an explicit topic of discussion in the campaign, an elimination or phasing out of New York’s rate setting system would be consistent with the new Governor’s general perspective.

The change in administrations has brought a sweeping personnel change to the New York Department of Health for the first time in nearly two decades. Prior to the election, DoH and Department of Social Services officials had scheduled a meeting with officials from Maryland, Massachusetts, and New Jersey to discuss their respective experiences with hospital rate setting. By June, 1995, all but one of the 15 New York DoH officials present at the November 22, 1994 session had left state government. At the session, some officials candidly admitted that prior to the electoral upset, they anticipated “tinkering” and modest changes in the successor statute to NYPHRM V. [78]

Instead, the entire rate setting system is now under review by the new Health Commissioner, Barbara DeBuono, and the Legislature. In December, 1995, a 19 member Task Force, chaired by DeBuono, recommended to the Governor that “New York should move toward a system of negotiated rates for all non-Medicare payors.” [79] In March, 1996, Governor Pataki proposed rate setting deregulation to the New York Legislature along with substantial cuts in financing for medical education and indigent care. At the time of the writing of this final document, it was unclear whether deregulation would

^{li} Interview with Richard Gottfried, Chair, Assembly Health Care Committee, New York City, 7/20/95.

occur during the spring budget period or during the fall legislative session. ^{lii}Governor Pataki's election did not produce substantial changes in the Republican controlled State Senate, nor in the Democratic controlled Assembly. However, the latter institution is now the odd-person out in three way discussions on the future of the New York health care financing system.

Incomprehensibility/Regulatory Failure: The specific problems with the New York regulatory system were described in the previous section, particularly relative to the RAND assessment of the system's incomprehensible incentives and disincentives. The DeBuono report notes the overall successes of the system in slowing the rate of growth of hospital costs in the early 1980s, in protecting the financial solvency of vulnerable institutions, and in serving a large population of medically indigent. Its conclusions about the current state of NYPHRM appear to reflect a consensus opinion among policy makers about the system:

- 1) NYPHRM does not provide the economic discipline to contain costs.
- 2) NYPHRM affects a shrinking proportion of the market, thereby limiting its effectiveness.
- 3) NYPHRM maintains excess hospital capacity.
- 4) NYPHRM provides incentives to train too many physicians.
- 5) NYPHRM supports uncompensated care, but the funds are inappropriately targeted. [80]

The RAND Report recognizes the extent to which the New York rate setting system is simply out of sync with the current needs and requirements: "The health care environment has changed substantially in the past decade, so much so that even New York

^{lii} New York Times, March 21, 1996, page 1.

itself probably would not end up with the same NYPHRM methodology if it were starting from scratch today.” [80]

The Changing Interest Group Landscape: On May 9, 1995, the New York Council on Health Care Financing convened a special meeting of Council members along with representatives from New York hospitals, business, Blue Cross, health maintenance organizations, physicians, and consumers to discuss the need to transition to a new health care financing system. All the groups had been supporters and collaborative architects of the five versions of NYPHRM. At the hearing, with the exception of the hospital representatives who wanted clear guarantees concerning uncompensated care, graduate medical education, and hospital capital support, all other representatives endorsed the deregulation of the rate setting aspects of NYPHRM. The position of the hospital representatives was not to extol the virtues of continued rate regulation, but rather to argue for the add-ons that have become part of NYPHRM, and to cast doubts on an unfettered embrace of free market economics in the health care arena. One participant at the hearing recalled a question asked by Council Chairman Sen. Michael Tully: “Can you feel the tectonic plate shifting?”^{liii}

The year 1995 has been a year of other developments in rate setting that are unusual given New York’s regulatory history and culture. On March 2, 1995, key officials from the Business Council of New York State and the State Communities Aid Association (the state’s leading low income advocacy organization) joined together to send a letter to Governor Pataki urging: “it is time to abandon both rate regulation and the economic components of the certificate of need system.”

That same month, the Life Insurance Council of New York State (LICONY) and the State Communities Aid Association joined together to release a report whose title is

^{liii} Recalled by Gerry Billings, State Communities Aid Association, Albany, 6/30/95.

self explanatory: “NYPHRM’s Paradox: How New York’s Attempts to Stabilize Hospital Finances Lead to More Uninsured, Increased Health Benefit Restrictions, Reduced Hospital Utilization, & Weakened Hospitals”.

By June and July of 1995, when the New York interviews for this study were conducted, it was not possible to find a single interest group across the New York landscape that would indicate any degree of support for continuing the hospital rate setting functions of NYPHRM. There are strong voices advocating for remedial solutions to the needs for uncompensated care, graduate medical education, capital support, and the broad range of add-ons that have been funded through the Uncompensated Care Trust Funds. But there is not a visible supporter of continued rate setting among the hospitals, Blue Cross, HMOs, commercial insurers, physicians, labor, business, or consumer/citizen groups.

Anticlimax: NYPHRM V had been scheduled to sunset at the end of December, 1995. During the budget debates that lasted into June, the Legislature agreed to continue the system for an additional six months to the end of June, 1996 when its fate could be determined as part of the broader health agenda facing state government.

In some critical respects, the New York situation parallels that of New Jersey in 1992, when the decision to deregulate rate setting was peripheral to the central debate on the future funding mechanism for uncompensated care. 1996 is now being advertised by policy makers and others as New York’s “health care superbowl” with decisions looming on uncompensated care, rate setting, Medicaid managed care, changes in federal support, proposed restructuring of the New York City Health and Hospitals Corporation, and more.^{liv}

^{liv} Interview with Harold Iselin, New York Conference of HMOs, Albany, 6/29/95.

But the lack of support for rate setting demonstrated by the interest groups is also reflected in discussions with key policy makers:

“For me, some of the most important aspects of the system have been its ability to force payers to contribute to a variety of what I consider socially important activities such as graduate medical education, payment for bad debt and charity care, subsidies for the children’s health insurance program, paying for capital costs of hospitals, and the rest ... What I support is not so much the price regulatory aspects as much as the system’s add-ons or taxes that it requires the payers to pay for.”^{lv}

Gottfried’s Senate counterpart was equally blunt:

“There will be no more NYPHRMs. It’s just outmoded.”^{lvi}

Revival(?): In the life cycle model, this phase involves the application of new innovations, increased scanning, risk taking, diversification, and decentralized operations. These dynamics can be seen in the context of the current Maryland program. However, use of the term “revival” to describe developments in Maryland is more speculative than definitive. It suggests that a unique set of circumstances has enabled Maryland’s form of mandatory rate setting to survive the same challenges that have undermined the systems in the other three subject states; and it further suggests that the Maryland model potentially may prosper in a new era.

Maryland:

“The attitude in Annapolis is that motherhood, apple pie, and rate setting all go in the same boat.”^{lvii}

^{lv} Interview with Richard Gottfried, Assembly Health Care Committee Chairman, New York City, 7/20/95.

^{lvi} Interview with Kemp Hannon, Senate Health Care Committee Chairman: quoted in BNA Pension & Benefits Reporter, July 10, 1995.

^{lvii} Interview with Robert Kowal, CEO, Greater Baltimore Medical Center, Baltimore, 6/23/95.

“It’s the sacred cow of Maryland.”^{lviii}

“It takes on a ‘salute the flag’ connotation.”^{lix}

The Non-Collision with Managed Care: Maryland’s approach to HMO discounting is unique among the four subject states. Massachusetts rate setting administrators permitted wide open discounting of rates from its inception; New York rate setting regulators attempted to control the practice through Health Department oversight; and New Jersey rate setting authorities unsuccessfully attempted to prevent negotiated discounts from undermining its system. Through tight enforcement, Maryland rate setting regulators largely have prevented their network of HMOs from engaging in discounting practices beyond the four percent legally permitted under HSCRC regulations.

As has been shown, this regulatory brake does not appear to have discouraged the development and growth of HMOs in Maryland, which in 1993 had the fourth highest penetration rate among the 50 states. While all interview subjects were aware of the strong rate of HMO growth, none had certainty in their explanations. The large number of federal and state employees, and the perception of a high rate of hospital admissions (incorrect) were the most common responses. A number of subjects simply shrugged with uncertainty, and did not view the high penetration rate as a positive feature of the State’s health system.

The presence of for-profit HMOs in the state has made a difference in establishing a new set of voices that now openly question the rationale for continuing the mandatory rate setting system. The most outspoken of these is Jeff Emerson, head of New York Life’s Health Plus HMO, who points to his and other plans’ steady diversion of patients to

^{lviii} Interview with Deborah Rivkin, Exec. Dir., League of Life and Health Insurers, Annapolis, 6/20/95.

^{lix} Interview with Geni Dunnells, Exec. Dir., MD Assn. of HMOs, Annapolis, 6/22/95.

Washington, DC hospitals as evidence that the Maryland hospital system is more expensive than it need be in the new managed care environment. A plan representative outlines New York Life's outlook:

"If it were less expensive in Maryland, we have very smart people who would figure that out. But that's not the situation. It's not less expensive here ... Many of my colleagues would love to get rid of it (rate setting). We murmur it to each other. But they think it would be unrealistic or don't want to spend the political chits. We all have a delicate relationship because we all contract with the state. And there are thousands of state employees who belong to our plans."^{lx}

The pressures from the managed care environment have spilled over into the hospital community. One manifestation of this impact is that some hospitals are not using the full charge authority provided to them by the HSCRC to raise rates to maximum allowable levels. Banking of excess charge authority is becoming commonplace:

"In the last five years, GBMC has banked a significant amount of dollars in terms of our allowable charges. We've done it to be price competitive ... This year, we got a 21.8 percent rate adjustment, and we took 3.3 percent and banked \$31 million in allowable rates ... I estimate that half the hospitals are banking, not charging, because they don't need it."^{lxi}

Political Stability. In November, 1994, in the closest gubernatorial race in the nation, Democrat Parris Glendening defeated Republican Ellen Sauerbray, sustaining long term Democratic hold on that office, the Legislature, and the state's political culture that was mentioned in the Walker/Gray innovation indices earlier in this chapter. With a high proportion of state and federal workers, along with the highest proportion of African-

^{lx} Interview with Thomas Goddard, Dir. of Leg. & Reg. Affairs, New York Life Health Plus, Green Belt, 6/23/95.

^{lxi} Interview with Robert Kowal, CEO, Greater Baltimore Medical Center, Baltimore, 6/23/95.

Americans outside of the deep South, Maryland has long been known as one of the most reliably liberal states in the nation.^{lxiii}

This culture has been reflected not only in support for rate setting, but also in the fact that the state has the highest number of mandated health benefits in its insurance statutes of any state in the nation, and also in the steady pace of intervention in the health sector by the Legislature, whether in placing new restrictions on managed care practices such as so-called "drive through" maternity deliveries, or in moving to make physician costs part of the rate setting program.

Interviewees were divided on the question of whether a Sauerbray election would have changed the outlook for continuation of all payer hospital rate setting. But what is undeniable is that the political shift that occurred in the other subjects states where broad deregulation reached the public agenda -- with party changes in the governor's office in Massachusetts and New York, and legislative changes in New Jersey -- has not happened in Maryland.

Regulatory Stability and Flexibility: Once again, a sharp contrast can be viewed between Maryland and the other states. The HSCRC has used its statutory flexibility to develop alternative methods of rate determination and payments that allow the system to evolve with changes in the market. Because system changes in the other three states required legislative approval, the other states were unable to engage in broad experimentation at the regulatory level. Indeed, the basic regulatory tools used by the HSCRC today -- Guaranteed Inpatient Revenue, and Total Patient Revenue systems -- began in the early 1980s as experimental ventures. The most important experiment in recent years has allowed hospitals to develop capitated models that do not undermine the basic tenets of the all payer system. This is a challenging venture that represents a

^{lxiii} Washington Post National Weekly Edition, November 13-19, 1995.

markedly different vision of the structure and role of hospital rate regulation. HSCRC documents explain the rationale for this new policy initiative:

“The assumption of risk by hospitals is both appropriate and desirable. Hospitals can assume risk and still adhere to the fundamental principals of the Maryland system. In fact, some new payment systems can complement the rate setting system. The rate setting system has been successful in controlling hospital charges per admission, but it has been less successful in controlling the use rates of hospital services. This outcome confirms a belief held by the HSCRC that physicians, not hospitals, dictate admission rates. Payment systems that seek to align the incentives of hospitals and physicians in order to enhance efficiency and the appropriate use of services should redress this shortcoming.”^{lxiii}

This latest round of experimentation began in earnest in 1994 with HSCRC approval for an experiment at North Arundel Hospital to deviate from the commission approved rates for up to 25,000 patients who are covered by area HMOs and under contract with physicians.^{lxiv} Supporters of the HSCRC view this new round of experimentation both as a sign of strength and as vitally important for the future stability of the Maryland system:

“This will very rapidly evolve into a new system as we transition quite rapidly from fee for service into global payments ... Once we were looking at a ten year horizon for these changes. We now think that in two to three years, we will be where we thought we would be in ten years ... We’re at the cusp of a revolutionary change.”^{lxv}

Not all are convinced that these experiments with capitation are a sign of strength in the system:

^{lxiii} Alternative Method of Rate Determination: Overview of Proposed Policy:
HSCRC, July 5, 1995

^{lxiv} Baltimore Sun, March 3, 1994

^{lxv} Interview with Larry Lawence, Exec. VP, MD Hospital Assn. Lutherville,
6/21/95.

"If they opposed these changes outright, they might have enemies that they really don't need. It keeps the wolf away from the door."^{lxvi}

Meanwhile, Maryland hospitals are engaged in mergers, affiliations, joint ventures, and other new market strategies, the same pattern visible in all 50 states today. In May, 1994, for example, Johns Hopkins Hospital announced plans with seven other hospitals to establish the Atlantic Health Alliance, bringing together 15,000 workers, 4,500 physicians, and \$1.3 billion in revenues -- all for the purpose of competing more effectively for HMO contracts.^{lxvii}

The Stable Interest Group Landscape: Any individual or group seeking to deregulate the Maryland rate setting system has a substantial obstacle to overcome in the form of the federal Medicare waiver that has been granted to the state since 1978, and that has been part of federal law since 1980. Because the waiver requires the federal government to pay a proportionate share of the state's uncompensated care obligation, the value of the waiver is estimated by the HSCRC at about \$200 million, or half of the state's \$400 million bill for hospital indigent care. That means that any move to deregulate starts out \$200 million in the red as compared to the costs of maintaining the system. Interviewees were well aware of the importance of the waiver to the state and to the continuation of hospital rate setting:

"It (the waiver) is crucial, vital, the centerpiece of the system." ^{lxviii}

"If we were ever to lose the waiver, we would lose the regulatory system."
^{lxix}

^{lxvi} Interview with Livio Broccolino, Chief Legal Officer, MD Blue Cross, Owings Mills, 6/22/95.

^{lxvii} Baltimore Sun, May 6, 1994

^{lxviii} Interview with Robert Murray, MD Health Cost Review Commission, Baltimore, 6/21/95.

^{lxix} Interview with Ernie Crofoot, MD AFL-CIO, Bowie, 6/22/95.

"For several years, they had to go to Congress to change the base ... they said plainly that if we didn't change the base, we would lose the waiver ... If you lost the waiver, the reason for the regulatory system would cease." ^{box}

"This system has its roots in the waiver. They're inextricably tied." ^{boxi}

"It's (the waiver) very important. If we lost the waiver, the system would start to disintegrate ... but the \$300 million is not the reason that we maintain the system." ^{boxii}

Nonetheless, calls have been issued for a renewed look at Maryland's approach to hospital and health sector regulation. In a February 6, 1995 letter to Governor Glendening, Wayne Mills, Chairman of the Board of the Maryland Chamber of Commerce, called for "a fresh approach ... to questions surrounding the crisis in the regulation of health care in Maryland." Mills urged the appointment of "a consumer-oriented commission" to define the appropriate level of regulation "in an industry undergoing change as rapidly as the health care industry."

The Chamber's government affairs representative indicates that the organization is more frequently raising questions about the future of the rate setting system:

"We're moving to an environment that is more cost driven than ever before ... My discussions with Murray and Cohen indicate that they know it has to change. It has been because of that they have been giving waivers to hospitals to try different arrangements ... The concern is always how much better could it be?" ^{boxiii}

While the call for a re-examination was tentative, it was also heeded by the Governor and by members of the Legislature.

^{box} Interview with Geni Dunnells, Exec. Dir., MD Assn. of HMOs, Annapolis, 6/22/95.

^{boxi} Interview with Thomas Goddard, NY Life Health Plus HMO, Green Belt, 6/23/95.

^{boxii} Interview with Casper Taylor, Speaker, Maryland Assembly, Annapolis, 6/19/95.

^{boxiii} Interview with Miles Cole, MD Chamber of Commerce, Annapolis, 6/24/95.

Anticlimax: A familiar dynamic in the new health system involves out-of-hospital health facilities performing profitable services that were once only done in the hospitals, and doing those services for far less than hospitals' real costs. In 1984 in Maryland, the spotlight landed on the 85 one-day surgical centers taking slices of hospitals' most lucrative procedures. Because the surgical centers are not part of the rate setting system, they are permitted to charge whatever the market will bear, and to cut prices far below approved hospital charge levels. Additionally, the "surgi-centers" avoid many of the obligations, such as community benefits and uncompensated care, and open door policies for the medically indigent that are thrust upon the acute hospitals. As the market share of these new facilities began to grow in the early 1990s, hospitals began to demand action from state policy makers.

In November, 1994, a special Task Force appointed by then-Governor William Donald Schaefer recommended that one day surgical centers be obligated to share with hospitals the expenses of uncompensated care to uninsured persons.^{lxiv} Rate setting and hospital allies in the legislature filed bills for the 1995 session, chiefly Senate Bill 639 relative to the Licensing of Freestanding Ambulatory Care Facilities (defined as ambulatory surgical facilities, endoscopy facilities, facilities utilizing major medical equipment, kidney dialysis centers, and birthing centers), to create a special licensure category for free standing surgical centers and also to "address the problem of discrimination based on payer class. Ambulatory care facilities should be required to provide access to all patients, regardless of their payer or insurance status as is the case with hospital based ambulatory facilities", according to hospital industry testimony.^{lxv}

^{lxiv} Daily Record, November 22, 1994

^{lxv} Testimony by Jane Stanek, Senior Director, Govt. Relations, Johns Hopkins Health Systems, March 2, 1995

The final version approved by the Legislature and signed into law as Chapter 499 by Gov. Glendening on May 25, 1995 was vastly changed in the legislative process. The new law requires only a study of the surgical center licensing issue and, responding to critiques issued by the Maryland Chamber of Commerce and other groups, "an evaluation of the all-payor system ... involving the Governor, the General Assembly, the Secretary of Health and Mental Hygiene, the State Insurance Commissioner, the Health Resources Planning Commission, the Health Services Cost Review Commission, the Health Care Access and Cost Commission, the Maryland Chamber of Commerce, hospital employee unions, and other organized labor groups, health care providers, health insurers, managed care organizations, and health care recipients." ^{bcxvi}

While calling for this review, the Legislature also endorsed a preamble that states that "the all-payor hospital rate regulatory system is the cornerstone of Maryland's longstanding history of pioneering, innovative public policy relation to health care delivery that is tailored to the unique needs of the citizens of this State ... this system serves as a national model that has successfully demonstrated that the cooperative establishment of appropriate incentives can yield enormous social benefits as well as successfully control costs ... Maryland hospital costs have gone from 25 percent above the national average in 1977, to more than 8 percent below the national average in 1994 and the reduction has saved government, business, labor and consumers in Maryland more than \$10 billion ..."

^{bcxvii}

Thus, the call for a review and assessment of Maryland rate setting was strongly couched in language indicating strong support for the structure and principles of the

^{bcxvi} Chapter 499, 1995 Acts and Resolves

^{bcxvii} *ibid.*

current system. This assessment was reiterated repeatedly in interviews with key policy makers who see no major changes in the offing:

"If it ain't broke, don't fix it. We feel very protective of our rate setting program ... There's a lot of trust that policy makers have put into that commission (HSCRC)." ^{lxviii}

"We continue rate setting because we believe that we've got a model regulatory system for the country." ^{lxix}

One other related issue that is currently facing Maryland policy makers is the treatment of uncompensated care in the system. Unlike the structures in Massachusetts, New Jersey and New York that pool funds for redistribution among more needy hospitals, Maryland's rules simply allow each hospital to build its uncompensated care costs into its allowable charge structure. Thus uncompensated care costs add about 15 percent to bills at Liberty and the University of Maryland Hospitals, both inner city, 11 percent at Johns Hopkins, and only 5.3 percent at Greater Baltimore Medical Center, and 3.5 percent at suburban Towson Hospital. The MHA has endorsed a proposal that would require suburban hospitals to pay more and the city hospitals to pay less, thereby shrinking the rate differential between them. Strong divisions exist within the hospital industry over the matter. ^{lxx}

Overall, Maryland stands in sharp distinction from the other three subject states on the critical factors used throughout this study to explain the deregulation process: managed care discounting, political change, regulatory stability, and interest group support.

^{lxviii} Interview with Sen. Paula Hollinger, Senate Chair, Joint Committee on Health Care Delivery & Finance, Annapolis, 6/20/95.

^{lxix} Interview with Casper Taylor, Speaker, MD House of Delegates, Annapolis, 6/19/95.

^{lxx} Baltimore Sun, April 27, 1995

Summary Comments: The twin themes of interests and ideas will be dissected in great detail in the subsequent chapters of this study. While interest groups are strongly a factor throughout the lengthy histories of the rate setting programs, we can observe that the predicted patterns and hypotheses of the theory of economic regulation are hard to find. The predicted cartels, so central to the theory of economic regulation, are not at all apparent in the four states, with different interests presenting themselves as potential candidates during each separate phase, including the hospitals, the regulators, the state health purchasing agencies, the insurance industry, and the business community. The only group that can readily be dismissed from the list of candidates is the consumer representation.

Regarding policy ideas and the punctuated equilibrium model, we can observe a strong policy idea influence at the birth and decline stages, with less importance during the growth and maturity stages. This disjuncture is consistent with the predictions of the punctuated equilibrium model. Once the policy monopoly and the prevailing ideas are established, the debate on ideas moves to the background. New ideas germinate slowly, and not necessarily in the full view of the public. To determine the fullest applicability of both models, we must return to an examination of the specific hypotheses associated with each theory.

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CHAPTER V

INTERESTS AND THE FATE OF HOSPITAL RATE SETTING

“There are a number of forces that could come together that could destabilize everything. The loss would put the hospital industry at grave risk. If you have deregulation, then it’s like road kill -- everyone’s in here plucking this piece or that.”^{lxviii}

It is clear from the preceding case histories that interest groups have played an important role in developments affecting rate setting systems from the beginning and throughout their full life cycle. To suggest anything else would be naive. Understanding the actions, strategies, and *ideas* of interest groups is critical in understanding the moves and motives of the various policy makers. Of specific importance in this chapter is the extent to which the movements by the various interest groups led to the demise of rate setting in three states and the continuation in one other. We also examine whether the behavior of interests conforms to the predictions specified in the theory of economic regulation. In this chapter, we will seek the clearest possible answers to the theory’s applicability.

The chapter will proceed in two parts. First, we will review the actions, strategies, and roles of the major interest group constituencies in turn, from the broad perspective of all four states, and during all four time phases. The specific interests discussed include: hospitals, Blue Cross, commercial insurers, health maintenance organizations, business,

^{lxviii} Interview with Dr. Martin Wasserman, Commissioner, MD Dept. of Health & Mental Hygiene, Baltimore, 6/23/95.

labor, consumers, and state government in its dual roles as rate regulator and as purchaser of health services. The specific role and activities of legislative and executive officials as setters of health policy will be left for chapter six, our examination of policy ideas. Physicians are not included in the list of examined groups because their distinctive role in rate setting policy was not significant in any of the four states.

Second, we will return to the hypotheses outlined in chapter two relative to the theory of economic regulation. We will examine each hypothesis in turn to determine whether the weight of evidence supports or does not support its validity as an explainer of rate setting policy and politics in the subject states. The hypotheses are specified in table 5.1 below:

Table 5.1: Theory of Economic Regulation Hypotheses

E1.	Rate setting should work to the benefit of hospitals more than to consumers.
E2.	Shifts in the configuration of interest groups supporting and opposing rate setting's continuation should accompany deregulation.
E3.	Similar shifts in identifiable support should not be observable in Maryland where rate setting has not been deregulated.
E4.	Elected officials should only play a secondary role in policy decisions about rate setting, with key interest groups setting the policy agenda.
E5.	Identifiable shifts in overt political support from affected interests to key legislative leaders should be identifiable in the deregulation process.

One critical (and recent) decision in this study is the inclusion of New York with Massachusetts and New Jersey among the deregulated states rather than with regulated Maryland. Even though New York's rate setting system has not been deregulated as of the writing of this study (and was originally intended to be categorized with Maryland), its deregulation decision is expected and predicted during the 1996 New York legislative

session. As was outlined in chapter four, all key ingredients leading to deregulation in Massachusetts and New Jersey are visible in mature form in New York at this time. Inclusion of New York with Maryland would lead to questionable and flawed analysis and conclusions.

Before proceeding to the discussion of specific interest group activities, we will briefly review the key elements of the theory of economic regulation as they relate to hospital rate setting, and as presented in chapter two. Stigler, who is most responsible for the development of the model, asserts that "as a rule, regulation is acquired by the industry and is designed and operated primarily for its benefit." While government has four principal tools at its disposal in regulating -- direct subsidy, control over entry, control over substitutes and complements, and price fixing -- "(E)ven the industry that has achieved entry controls will often want price controls administered by a body with coercive powers." [1]

Equally clear in Stigler's model is the limited role of public officials. "The players who count in regulation are the producers and consumers. Political intermediaries -- parties, legislators, administrators -- are not believed to be devoid of influence, but in the main, they act as *agents* (emphasis added) for the primary players in the construction and administration of public policy." Stigler outlines three limitations to regulated industries: 1) power arrangements within the regulated industry are changed and become non-proportional to industry output; 2) substantial costs can be incurred from compliance with public safeguards; and 3) industry councils are opened to potentially powerful outsiders through the public process. All of these impediments must be outweighed by the economic advantages obtained through regulation. In return, the industry "must be prepared to pay with two things a party needs: voters and resources." [2]

Stigler did not apply his model to instances of deregulation, which began to occur prominently in the late 1970s. Feldstein has applied the theory of economic regulation to both the health sphere and deregulation. In his model, regulation is demanded by health

provider groups because of the benefits that it provides, and is supplied by compliant legislators at the price of political contributions, votes, and volunteer time; it is further supplied by compliant regulators at the price of political support for the agency's continued operation and expansion. For consumers, high information and transaction costs usually exceed the diffuse benefits of defeating regulation, explaining why the regulated industry usually wins out over them. Deregulation is predicted to occur when political support by the regulated industry declines or when political support from regulatory opponents increases beyond the political benefits offered by those regulated. [3] Becker suggests that support for deregulation will grow when the dead weight cost of a regulatory structure becomes too large to sustain. [4]

Interest Groups' Role in Rate Setting and Its Demise

Hospitals: The discussion of hospitals as the first interest group is not coincidental. As the previous section makes clear, hospitals must be at the critical center of the rate setting discussion if the theory of economic regulation is to hold. As the regulated "cartel," hospitals should have engineered the creation of mandatory rate setting by compliant legislators who were responding to hospital needs. Hospital interests should come first in the distribution of rate setting benefits -- before the needs of consumers, insurers, government, business, labor, or others. Deregulation should occur for any of several possible reasons: because the objective benefits of rate setting to hospitals have changed, because hospitals were unsuccessful in obtaining needed benefits from the system, because hospitals were politically divided, or because other groups have developed or organized to defeat hospital efforts to maintain the existing system.

In this analysis, we examine the evidence presented in chapter four to seek confirmation of the theoretical hypotheses. One immediate and striking feature of the rate setting case histories from the four subject states is the variety among them in every phase

and on nearly every facet. Perhaps the only consistency among the four states during the four phases in rate setting's life cycle is that hospitals have been central players in each one of the 16 possible "cells." Sometimes they achieved their objectives, sometimes they lost, and sometimes the results were mixed for them. But hospital leaders never allowed their institutions to be taken for granted.

Presented in the table below is an evaluation of the success record of hospitals in the four subject states in meeting their own objectives during each segment in the life cycle model, indicating whether hospitals achieved their objectives (+), lost out (-), or experienced a mixed outcome (0) in shaping the direction of their respective state rate setting programs to their own advantage. Hospitals are viewed as having achieved their objectives if the main public policy decisions during the period were consistent with their own aims.

Table 5.2: Hospital Experience Under Rate Setting

	Birth	Growth	Maturity	Decline/Revival
MD	+	+	+	+
MA	-	0	+	0
NJ	-	-	+	0
NY	-	-	0	0

An alternative subtitle to this study could easily have been: "Except for Maryland..." because -- except for Maryland -- the results for hospitals in each state under rate setting have been mostly negative or mixed. The two clearly victorious periods in Massachusetts and New Jersey were followed rapidly and not coincidentally by deregulation. The rationale for the "grade" in each cell is provided in turn.

Birth: Examining the birthing phase of hospital rate setting in the four states, we observe that the Maryland Hospital Association not only supported its establishment, but

actually wrote the enabling legislation in its offices. However, that support came only after major structural changes in the makeup of the association, changes not replicated in any of the other 49 states. Prior to the change, the CEO-dominated MHA routinely and vigorously opposed rate setting legislation dating back to the first bills filed in 1967. The newly organized and trustee-dominated MHA in 1971 supported rate setting to avert stronger federal controls, to develop a more effective model than retrospective cost-based reimbursement, and to free themselves from the yoke of the arbitrary rate setting determinations made by Blue Cross of Maryland. *(Grade: +)*

Massachusetts hospitals did not seek rate setting controls; rather they were compelled to swallow Blue Cross and Medicaid charge controls in 1975 and 1976 as an alternative to the Dukakis proposed charge freeze that they fought. They successfully opposed the freeze. But in the process, legislative leaders became convinced of the need to address structurally a gaping budget deficit and rapidly increasing Medicaid costs by imposing major structural controls on their operations. *(Grade: -)*

New Jersey hospitals were anxious in the early 1970s to win adoption of certificate of need controls that would establish limits on entry to keep for-profit hospitals out of their state. In this respect, the New Jersey Hospital Association's activities most resemble those of Stigler's cartel. But the hospital community opposed the budget oversight and controls that were part of the State's bargain. State policy makers were determined to find a means to hold down growth in Blue Cross premiums, whose explosive increases were attributed largely to hospital cost inflation. Once established, the NJHA did their best to direct and subvert the budget controls, but there is simply no evidence to suggest that hospitals sought the establishment of these controls. *(Grade: -)*

As described in chapter four, the Hospital Association of New York State (HANYS) actively opposed the establishment of controls on them for Blue Cross and Medicaid charges in 1969 but was unable to prevent legislative enactment because of long

standing state concerns about the growth in Medicaid costs and hospital costs in general that dated back to at least 1964. (Grade: -)

Growth: Because Maryland hospitals had been central partners in the legislative creation of mandatory hospital rate setting, their influence can be seen in the critical phase of implementation leading up to the attainment of the federal Medicare waiver. The selection of a hospital CEO as the first chairman of the HSCRC lends further weight to the suggestion of cartel-like behavior. Two facts undermine that conclusion. First, the initial implementation period witnessed a spate of legal suits challenging many aspects of the system, with most of these legal actions initiated by hospitals or groups of hospitals dissatisfied with the new regulatory framework. Second, it is during this phase that the system began its steady 19 year descent in hospital costs per admission and per capita. A central assertion of the theory of economic regulation is that the regulated industry should reap more financial benefits under regulation than without it. While Maryland's performance during this phase may not rule out the applicability of the model, it certainly leaves its applicability open to question. Nonetheless, the MHA maintained support for the system during this period, and achieved its key objectives. (Grade: +)

Another feature of the economic regulation model suggests that "the regulatory agency will enable the different firms to act as a cartel, raising prices, restricting output, and providing firms with higher profits than if regulation did not exist." [2] But the growth period saw Massachusetts hospitals locked in intense and protracted struggle with Rate Setting administrators, Blue Cross, commercial carriers, and a newly assertive business leadership over the rules of the system. In this and subsequent periods in Massachusetts, hospitals attempted end-runs around cost conscious regulators by seeking more favorable treatment from friendly legislators. Rather than victory, the fierce political struggle that culminated in the enactment of the all payer system under Chapter 372 was instead the best deal hospitals could win under the circumstances. The advent of national prospective payment in Medicare provided hospitals with a short-lived rationale to

embrace all-payer rate setting to avert the threat of more intrusive federal restrictions. But to hospitals, it was making the best of a bad bargain. (*Grade: 0*)

New Jersey hospitals had been able to turn the lemons of state mandated budget controls into the lemonade of a NJHA-run operation that established ineffectual limits on their growth. But political embarrassment over these loose controls led to the imposition of the state-run SHARE program's strict financial limits, and subsequent financial deterioration for urban hospitals. Hospitals reluctantly agreed to the imposition of the nation's first DRG controls to ameliorate the worst aspects of the SHARE program, and - similar to hospitals in Massachusetts and New York -- agreed to seek a Medicare waiver only to avert feared federal reimbursement changes. (*Grade: -*)

New York hospitals saw a severe financial crisis during their growth period as state regulators and lawmakers used their newly established controls to ratchet down both Medicaid and Blue Cross reimbursement levels. It was little comfort to them that commercial insurers and self-pay patients faced their own drastic financial squeezes. The process that led to the establishment of NYPHRM softened some of the harsher aspects of the prior reimbursement scheme, but did so with a regulatory model that controlled all of their charge authority, not just that of Blue Cross and Medicaid. This phase led to the creation of the eight regional uncompensated care pools which helped hospitals to address charity care and bad debt needs. However, it was not until the maturity phase that the crisis for hospitals began to materially abate. (*Grade: -*).

Maturity: Maryland's progress during this phase reflected remarkable stability and consensus among the key constituencies both inside and outside of government. The major threat to hospitals was the potential loss of the dollars associated with the Medicare waiver, and the accompanying loss of stability. Health care reform appeared frequently on the state's policy agenda, but hospital rate setting was seen as part of the solution, and not as part of the problem. Hospitals were major supporters of the rate setting system during

this period. The steady decrease in the rate of growth in hospital charges relative to the national average, however, undermines the cartel thesis. (Grade: +)

This phase in Massachusetts consists of two parts. The early phase was one of tight controls on hospital charge increases, and a real lowering of per-admission charges. But hospitals organized strongly for the political cycle that ended with the enactment of Chapter 23 in 1988, and won major financial concessions that erased most of the decreases in hospital spending growth that had been achieved earlier in the decade. The Chapter 23 phase was one of major financial infusion for most hospitals -- but a victory won from legislators over the opposition of the regulatory and Administration officials. (Grade: +)

The New Jersey experience during this phase mirrors that of Massachusetts: early successes by the DRG system in holding down hospital cost inflation, followed by massive reinflation as regulators and legislators lost their capacity to hold down system costs. Though Massachusetts' erosion can be tied directly to the decisions of legislators in response to hospital lobbying, the New Jersey erosion can be attributed more to regulatory failure, and the inability of system managers to cope with the volume of appeals, retrospective settlements, and severe structural problems with the Uncompensated Care Trust fund. (Grade: +)

The NYPHRM system saw its severest financial pressures in the late 1980s during NYPHRM III, a response to the more generous levels of reimbursement permitted in version II. Policy makers came back and pumped substantial new levels of cash into acute hospitals in versions IV and V, leaving New York with the worst of all possible worlds -- hospitals with costs among the highest in the nation, and hospitals with the weakest financial condition of any comparable set of institutions in the nation as well. (Grade: 0)

Revival/Decline: Maryland faces questions about the future of its rate setting system with a strong base of political support, and a track record of achievement and flexibility. A strong base of support, though not unanimity, exists among hospitals in

support of the system. A large part of this consensus is held together by the estimated \$200 million in benefits to the state through continuation of the Medicare waiver. As one longtime observer and framer of the system observed:

“There’s no important political voice that wants deregulation to happen.” ^{locxii}
(Grade: +)

During Massachusetts’ deregulation phase, hospitals had a difficult time deciding on a direction. In December, 1990, MHA trustees voted to endorse continued regulation under a new-Maryland style framework. During 1991, with the new Weld Administration sounding strong pro-market themes, leaders of major teaching institutions began to promote actively a deregulation and market strategy. But many other institutions were far less certain, and feared the economic ramifications of full competition. Ultimately, MHA leaders backed deregulation in the fall of 1991, but only when the likely direction was clear, and only after they had won the removal of elements in the legislation not to their liking. The House Chair of the Health Care Committee gives her impressions of hospital political strategy:

“One thing I’ve learned about hospital CEOs is that they’ll go whichever way they think they’re going to be successful. They knew that the Weld Administration was hell-bent on this. They thought they had better get on board rather than to buck it ... they saw the writing on the wall.” ^{locxiii}

The former President of the MHA describes his organization’s ambiguity during the legislative process leading to deregulation:

“We would have preferred to see a standardization of discounting and a level playing field with a public utility aspect ... We did not feel that this model would succeed given the Blue Cross position ... One thing about

^{locxii} Interview with Eugene Feinblatt, attorney, Baltimore, 6/21/95

^{locxiii} Interview with Carmen Buell, House Chair, Joint Committee on Health Care, Boston, 12/28/94

competition is that everyone thinks that they'll be able to succeed based upon their own skills." ^{locxiv}

(Grade: 0)

New Jersey hospitals also faced serious splits within their ranks over deregulation proposals. Unlike Massachusetts, the academic medical centers sided with urban institutions in strong opposition to deregulation. Only the suburban hospitals, who dominated the NJHA, strongly backed the removal of regulatory controls on their charges. The result was a split in the organization with urban and academic institutions forming the Hospital Alliance of New Jersey, and abandoning the NJHA. Even the NJHA did not immediately seek deregulation, originally calling together the group that became the New Jersey Health Coalition for Health Care Reform only to find a fix for Judge Wolin's ruling that struck down the uncompensated care surcharges. Business, labor, and insurer groups pushed NJHA to back deregulation as a condition for their support of a UCTF fix.

(Grade: 0)

As New York policy makers move rapidly toward rate setting deregulation and a new era in health care finance, hospitals find themselves divided and uncertain:

"I was at one of the hospital association annual meetings last year. Jim Tallon asked how many administrators would like to see for profits who could purchase and close hospitals allowed in New York. One third of the hands went up for that and for competitive markets. One third clearly didn't want it. And one third really didn't know. I was surprised. I didn't believe that quite that many would want an open market. This has all happened within the last six months." ^{locxv}

Some of the differences in viewpoint are regionally based, with hospitals in New York City and on Long Island strongly in support of continued rate setting and regulation,

^{locxiv} Interview with Stephen Hegarty, former President, Mass. Hospital Assn., Burlington, 12/21/94.

^{locxv} Interview with Ed Reinfurt, Vice Pres., Business Council of New York State, Albany, 6/30/95

while hospitals in areas such as the Northeastern part of the state "want to negotiate rates tomorrow ... It's destructive. You couldn't have more extreme positions." [5]

In spite of the hospital community's position, the consensus among all other key players in the system is that NYPHRM must go, and that replacement sources of revenue must be found for uncompensated care, graduate medical education, capital support, and the other access-add-ons that have been part of the Uncompensated Care Trust Funds. The political challenges are to set an agreed upon level of subsidization, and to find an agreed upon replacement funding source. All sides understand that these are the essential challenges for the 1996 legislative session. For hospitals, there is the additional challenge of finding their way in a new, market-oriented world that will be vastly different from the issues and problems that faced them before:

"The low hospitals margins in New York -- you can look back 70 years or the whole 20th century -- it's because our hospitals were built under a different ethos. They were all charitable, all non profit, many religious, many funded chiefly by philanthropy and voluntary contributions. The CEOs were rewarded for good community service, not for a good bottom line. Anyone can run a surplus in one year, but over time, people will question your mission. There's a never ending list of things you could spend your money on." ^{lxccvi}

"After some 20 odd years of regulation, we have a whole crop of hospital managers whose job is to manage bureaucrats and not to manage institutions. Part of the convulsions going on now are because we're so used to going up to Albany and trying to handle the bureaucrats -- now the focus is more on autonomy and individual responsibility on the part of the managers themselves. So there are withdrawal problems ... The New York system was designed to give hospitals no margins. Therefore, any time anybody had a crisis or needed extra financing, there was no surplus and the only way to deal with the crisis was to go to the regulators and look for favors." ^{lxccvii}

^{lxccvi} Interview with Ray Sweeney, VP, HANYS, former DoH Dir. of Health Systems Mgmt., Albany, 7/21/95.

^{lxccvii} Interview with Ken Raske, President, Greater NY Health Care Association, New York City, 7/20/95.

(Grade: 0)

One final feature of the theory of economic regulation that needs attention in light of subsequent hospital performance involves hospital net revenues. A fundamental aspect of the economic regulation model is that the regulated industry should reap profits that are greater than those that could be obtained in the absence of regulation. Yet in the case of mandatory rate setting, it is clear that hospitals in all four states enjoyed a level of profitability that was far below that realized by their peers in other states. This pattern crosses all four subject states, through good economic periods for hospitals and bad ones. This finding, as much as any other, is in direct and clear contradiction to the predicted results under the theory of economic regulation.

Over the span of 25 years of mandatory hospital rate regulation, we can observe repeated attempts by the regulated parties to act like a cartel; but we also see an inability on their part to do so in the face of resistance from other governmental and non governmental sources. We now turn to those other players to examine their behavior patterns more closely.

Blue Cross: In the absence of evidence demonstrating a cartel pattern on the part of the hospitals, we must be open to the possibility of identifying a replacement cartel composed of one or several interest groups involved in rate setting system policy and direction. An obvious candidate would be the Blue Cross plans of the subject states. The non-profit and state-chartered insurer is the only entity that was uniformly a part of the original mandatory rate setting statutes. Blue Cross plans were major players in the health insurance market in all four of the subject states and well positioned political players as well. But once again, when we examine the activities of Blue Cross plans in relation to hospital rate setting, we do not find strong uniformity in behavior, except in the final, deregulation phase.

While Blue Cross was one of the major interests pushing for the establishment of hospital charge controls in New Jersey, the opposite was true in Maryland. Maryland Blue Cross officials were able to take advantage of their structural control of the Maryland Hospital Association to force rates of payment acceptable to their own needs:

"They (Blue Cross) started out as a major player and controlled the hospitals. They said, 'if you don't give us this kind of discount, we're not going to pay you.' They fought the original law."^{lcccviii}

The battle in 1971 to establish hospital rate setting included a bitter struggle between Blue Cross and their former partner, the MHA. In the aftermath of rate setting's establishment, they were forced to live with levels of hospital payment that were higher than they would have seen in its absence. Some 25 years later, the scars have healed, but the memory of the battle and their ambiguous support for continuation of the system do not mark an organization that regards itself in the driver's seat in establishing health policy for the state:

"(Rate Setting) works OK for us. But there's another school of thought in the company: we have the largest market share, the largest indemnity base, and an extensive and affordable HMO presence. If the regulations were abolished, we probably could do very well in terms of negotiating with hospitals to obtain significant discounts, deeper than the way it currently works ... there's deep division. There always has been. It's old and long going. It goes back prior to the commission's establishment when we got much better deals than today."^{lcccx}

Blue Cross of Massachusetts was also involved in bitter struggles relative to hospital rate setting, though these battles primarily involved the commercial indemnity carriers more than the hospital community. Controlling about 25 percent of hospital business in the state, Blue Cross was able to use its substantial legislative influence to win

^{lcccviii} Interview with Eugene Feinblatt, Attorney, frn Chairman, MD Comm. on Health Care Financing, Baltimore, 6/21/95.

^{lcccx} Interview with Livio Broccolino, Chief Legal Officer, Blue Cross & Blue Shield of MD, Owings Mills, 6/2/95.

rules under the pre-all payer system (Chapter 409) that resulted in commercial insurers paying about 60 percent of the hospital uncompensated care costs, while they paid only 25 percent. Their principal interest in the 1982 battle was to keep their advantage and to establish the largest possible discount off charges relative to the commercial carriers. [6]

By the late 1980s, their keenest competition came not from commercial carriers but from the state's burgeoning group of HMOs. Because HMOs were able to offer lower premiums because of deep hospital discounts, Blue Cross began to see a hemorrhaging in its subscriber base, in addition to a major financial crisis documented in an extensive and public management review. [7] These related developments, together with a new top management team, brought an about face on continuation of hospital rate setting:

"By the fall of 1990, Blue Cross had an almost total turnover in upper management. We had reports from the Division of Insurance and others that the financing model would doom us to failure ... We were on the top end of the system in terms of the prices that we paid, and we were helping to subsidize the growth of our chief competitors, the HMOs." ^{xc}

Thus, Blue Cross became a strong and insistent voice in Massachusetts for deregulation in 1991, recognizing that the possibility of creating a Maryland-like model with no HMO discounting was not a realistic political option. Like the other insurers, their primary attention during the deregulation debate was focused on the elements of the bill creating new and standardized rules for participation in the small group insurance market, a key part of their business. By mid-1991, deregulation was already a given.

Like its counterpart in Massachusetts, New Jersey Blue Cross had been a key part of their state's rate setting system. Indeed, regulation of Blue Cross hospital payments existed before formal rate setting, dating back to 1938. Competition over the size of charge discounts characterized their relationship with commercial insurers. A difference

^{xc} Interview with Steven Tringale, former VP for External Affairs, Blue Cross, Boston, 12/21/95.

from their Massachusetts counterpart was that by the time of the deregulation debate, Mass. Blue Cross was already moving out of its severest financial stress, but New Jersey Blue Cross' crisis was just getting to its zenith. In 1991, New Jersey Blue Cross faced losses of \$83 million in its individual and small group lines of business. Seeing their future as tied to managed care, the insurer supported the elimination of rate setting, but focused its heaviest lobbying efforts on companion bills to reform the individual and small group insurance markets that were a critical part of Governor Florio's agenda and central to his agreement with legislative leaders in eliminating the DRG system:

"We supported elimination of the DRG system, but our biggest problem was the amount of losses in the individual market .. We had an \$80 million advantage under rate setting in reduced charges that we would lose, but we were more than willing to give it up." ^{xc1}

The situation for the five New York Blue Cross plans today resembles that of the Massachusetts and New Jersey plans far more than that of the Maryland plan. A deep financial crisis, a huge loss in its subscriber base, and an inability to compete with dynamic and growing HMOs are familiar themes that all characterize the New York situation:

"Blue Cross is now at about 17 percent market share, down from what used to be 38 percent ... NYPHRM treated them as if they had monopoly status, but they didn't control all the variables. What NYPHRM created at Blue Cross was an inefficient paper pushing operation where all the tough decisions were made externally and they were insulated from them. At the last count, they were big losers." ^{xc2}

The New York Blue Cross and Blue Shield Plans' current position is that rate setting should be eliminated as quickly as possible while preserving some of the policy add-ons of the NYPHRM model:

^{xc1} Interview with Dennis Marco, VP, Blue Cross and Blue Shield of New Jersey, Newark, 4/20/95.

^{xc2} Interview with James Tallon, Pres., United Hospital Fund, former NY State Assembly Majority Leader, Portland OR, 8/6/95.

"It's time to move to a more open competitive market immediately ... We hear a chorus of voices from all sides -- large employers, middle-sized employers, small employers and individuals, increasingly individuals, who now have a sense that rising health insurance costs are related to health care costs." ^{xviii}

There was a time when Blue Cross was the essential insurer of last resort in New York -- as well as in the other rate setting states. In 1992, the New York Legislature adopted a tough community rating law for individual market insurance products that has effectively removed Blue Cross from that role. New Jersey's individual market reforms in that same year had the same effect through a different mechanism. These developments in both states indicate that the insurer retains significant political clout. As plans in all four subject states examine their respective future prospects, conversion to for-profit status is a realistic option for consideration, and has already been permitted in a limited form in Maryland and is under consideration in New Jersey.

We can observe in all four subject states a clear parallel between the profile of their Blue Cross plans and the state's regulatory climate. At times, we can observe Blue Cross plans leading, and at other time following the different transitions. They are always heavy weight players, but they never dominate the debate. They generally operate independently, and have only short-term alliances with other different health sector players.

Commercial Insurers: This combination of interest groups has a fascinating, albeit limited, part in the rate setting story in our subject states. An important structural feature of commercial indemnity carriers is the limited market share of any single carrier in almost any given market in the subject states. That limited market share provides the insurers with very restricted leverage in winning concessions of any sort from acute hospitals -- financial, regulatory, or political. Large national carriers traditionally had been

^{xviii} Dave Oakley, Counsel to New York State Blue Cross and Blue Shield Plans, Albany, 6/29/95.

more interested in a large number of subscribers from across the country than in substantive penetration in any one market. By contrast, the new strategy for those carriers choosing to stay in the health insurance market today is to focus on building large concentrated market shares in a limited number of locales to enable them to leverage discounts and concessions that had been going primarily to HMOs and aggressive Blue Cross plans.

Because of their limited roles, commercial carriers were left out of the original rate setting schemes in Massachusetts, New Jersey, and New York. The cost shift that immediately fell upon them was a harsh wake up call to the industry. Commercial insurers were brought into the rate setting fold only after serious political battles in those three states.

Nationally, the Health Insurance Association of America became one of the biggest boosters of mandatory hospital rate setting in the late 1970s and early 1980s. Indeed, some of the key scholarly articles seeking to demonstrate the empirical value of state based hospital rate setting were written by economist Carl Schramm, who later became HIAA's national president. [8] [9] While HIAA has never formally abandoned its position in support of all payer rate setting, it has also clearly moved away from its prior enthusiastic boosterism. The key reasons for the switch include the industry's rapid embrace of managed care and a different paradigm for running their businesses and controlling hospital expenditures.

Even in Maryland, the loss of enthusiasm for mandatory hospital rate setting is apparent among the State's commercial carriers:

"Recently I called a number of my companies that were on record in support of the HSCRC in the early days. They have all changed their position. I understand that HIAA has a paper in draft form changing their position. The principal reason for that is managed care ... The (Maryland)

rate setting program is clearly the best in the country -- if you have to have one."^{xciv}

Nonetheless, the commercial carriers will only embrace deregulation in Maryland if they are convinced that the prospects for that change are realistic.

In 1991 in Massachusetts, the commercial carriers -- which had not yet effectively transitioned to managed care -- were not ready to break the tie to mandatory hospital charge controls, fearing both a cost shift from hospitals, and a competitive disadvantage against Blue Cross:

"We were concerned that if managed care really led to tight contracts, that hospitals would just shift costs to us, and that fee for service charges would see the brunt of this shifting ... Removing the compulsion for Blue Cross to contract with every hospital would mean that they could dictate their prices and be even tougher. So instead of an 800 pound gorilla, they would become a 1,000 pound gorilla ... So our amendments actually proposed continuing the rate setting system ... We maintained that position, but nobody was buying it."^{xcv}

In New Jersey, these misgivings were not apparent in 1992 in a state dominated by large players in the commercial insurance market such as Prudential, Aetna, and CIGNA, companies that "all decided that their future in the health insurance industry lay with managed care. Thus none of these prior supporters of rate setting remained in its favor (similar reasoning led these private companies to leave the national health insurance lobby, which was dominated by small insurers still offering indemnity plans)." [10] In addition to concerns about the evolving market for health insurance, officials at the commercial carriers were also fed up with the regulatory failure that characterized the New Jersey system:

^{xciv} Interview with Deborah Rivkin, Exec. Dir., League of Life & Health Insurers of MD, Annapolis, 6/20/95.

^{xcv} Interview with William Carroll, President, Life Insurance Association of Mass., Boston, 12/29/94.

"It was an idea whose time had come and gone. The reconciliations had become extremely cumbersome. The board had become a giant bureaucracy. The biggest problem for us was the retroactive charges -- we couldn't tell what the trend factor would be until the Rate Setting Commission had finished their reviews, and then we had to make 4-5 percent changes to cover past increases and retros ... We had no ability to predict costs, and we couldn't get moving on managed care." ^{xvii}

Four commercial interests (AETNA, HIAA, Multiplan, and Prudential) were members of the New Jersey Health Care Reform Coalition that publicly endorsed a move to rate setting deregulation in September, 1992.

In New York, the commercial insurers association, the Life Insurance Council of New York State, formally and for the first time voted in the spring of 1995 to support the end of NYPHRM:

"There was no big announcement. It may have been April or May before the final vote. It was a long meeting but not heated. One member didn't think we should deregulate right away because they didn't feel ready ... We realize that going to deregulation may mean the deathknell for some of our people, the people who aren't ready to negotiate. Before community rating, we just wanted a level playing field with Blue Cross. Dereg is a big step toward a level playing field." ^{xviii}

Prior to the actual decision to endorse deregulation, LICONY financed a study on the NYPHRM system by a consultant who formerly had worked for the State Department of Health. As we will review in chapter six, that study played a critically important role in promoting the policy idea of deregulation. The study was co-sponsored by the low income advocacy group, the State Communities Aid Association. SCAA's Director, as we have seen, has publicly advocated deregulation on the same platform and in the same letters as leaders of the State's Business Association. Thus, a three way collaboration

^{xvii} Interview with Dana Benbow, Vice President, Prudential Insurance Company, Iselin, 4/19/95.

^{xviii} Interview with Diane Stuto, Vice President, LICONY, Albany, 7/21/95.

among consumers, commercial insurers, and business was formed for the purpose of moving New York away from its hospital rate setting “habit.”^{xviii}

While commercial insurers have only recently endorsed deregulation, they were responsible for a potentially fatal challenge to the system in the form of a legal challenge that reached all the way to the US Supreme Court in April, 1995. In the early 1990s, the State responded to its own and Blue Cross’ fiscal crises by raising the charge differential between Blue Cross/Medicaid rates and those of commercial carriers from 13 to 24 percent. In January, 1993, a New York federal district court judge ruled that NYPHRM’s payer differentials violated the federal ERISA law.^{xcix} While not challenging the entire New York rate setting structure, observers saw a clear parallel between the “Travelers Case” and the “United Wire Case” that precipitated the New Jersey deregulation process in May, 1992.

But on April 26, 1995, the US Supreme Court ruled unanimously that indirect effects on employer sponsored health plans -- such as NYPHRM’s differentials -- were not grounds for ERISA pre-emption. While the decision gave the state breathing space in deciding the future of NYPHRM, (and pleased other state-based health reformers by providing expanded health reform options) it did not lead to any calls for a reinvigoration of hospital rate setting regulation, but only a more orderly exit strategy:

“We were not happy to be on the losing side. But it had made it easier for lawmakers to work with an add-on type of thing to fund social needs post NYPHRM.”^c

^{xviii} Richard Kirsch, Executive Director, NY Citizen Action, Albany, 6/29/95.

^{xcix} Travelers Ins. Co. v. Cuomo, 14 F. 3d. 708 (2d Cir. 1994)

^c Interview with Diane Stuto, Vice President, Life Insurance Council of NY, Albany, 7/21/95.

Viewing the range of commercial insurer interests in hospital rate setting, we again observe not a cartel dominated by hospitals or any other group, but rather an ongoing struggle -- or a multiple tug-of-war -- that finds different coalitions joining together at different ends of the rope in each distinct phase. As with the hospitals, the commercial carriers have their wins and their losses, but they don't resemble dominant winners by any stretch.

Health Maintenance Organizations: Central to deregulation versions of the theory of economic regulation is the predicted emergence of a new interest that upsets the prior equilibrium and changes the dynamics and interests of the cartel. In the rate setting story, that role would clearly belong to health maintenance organizations, less than a footnote at the inception of hospital rate regulation in the early 1970s, and major institutional players in all four subject states today.

Prior to the coining of the term "health maintenance organization" by Ellwood, prepaid group practices around the nation were small, not for profit, and insignificant with the major exception of the California Kaiser Plans. A series of federal laws beginning in 1973 sought to encourage their growth as a response to health cost inflation, laws that were viewed as largely ineffectual. [11] When the Reagan administration ended the special federal grants program for HMOs in 1981, many of these organizations moved into the welcome hands of investors who recognized opportunities for significant financial gain in the burgeoning field of for profit medicine. Coming at a time of medical cost hyperinflation, the new for-profit managed care organizations experienced rapid increase in growth and development that continues into the 1990s. [12]

The stunning growth of HMOs in tightly regulated Maryland during the past seven years caught many policy makers and observers by surprise in ways both welcome and unwelcome:

"I can't quite explain it, but right now Maryland is number three for managed care penetration. The biggest screamers to dismantle our all payer system are the HMOs, out of state entities, and all they want is further discounts, and to get people out of their normal sources of care. There's a war going on."^{ci}

Throughout the history of the Maryland rate setting systems, managed care organizations have not been influential, a fact which helps to explain why the HSCRC has been able to maintain and enforce tight limits on hospital discounting with HMOs. While some of the new, for profit organizations are actively talking about the need for deregulation, the Maryland Association of HMOs has not endorsed this position, but is straight forward in expressing its reservations about the rate setting system:

"The system is trying to move hospitals to a more competitive stance, but when you look at one hospital's application -- if they're trying to compete with ambulatory facilities down the road -- they have to face six months of review by the HSCRC, looking at risk and cost shifting. In the private market, you hire someone to assess what you have to do and you do it ... I don't think a regulatory system can keep up with market demands ... We're an industry that supports competition -- but our plans want to be satisfied with the results before they recommend dismantling the system."^{cii}

Thus while HMOs have gone far beyond the point of critical mass in the Maryland health insurance market, they have yet to make their mark on the state's political system, and have not themselves come to terms with the merits of deregulation.

HMO influence has been most apparent in Massachusetts. From the beginning in 1982, HMOs alone were allowed the ability to negotiate discounts of any amount with hospitals under the Chapter 372 all payer system. Thomas Pyle, the former head of the Harvard Community Health Plan, was an early voice and force for market dynamics in the State's health care policy circles, and compelled the private Health Care Coalition to bring in HMOs as a member group in 1983, when managed care penetration in the state was still

^{ci} Interview with Sen. Paula Hollinger, Senate Chair of MD Joint Comm. on Health Care Delivery & Finance, Annapolis, 6/20/95.

^{cii} Interview with Geni Dunnells, Exec. Dir., MD Assn. of HMOs, Annapolis, 6/22/95.

in single digits. The Mass. Association of HMOs was formed in 1985, in part to give other HMOs a voice in policy discussions equal to that of Pyle's. But during the fights over the legislation that became the 1988 Universal Health Care Law, the strategy was largely defensive:

"In Chapter 23, we were dancing among the elephants. Pat McGovern (Senate Ways and Means Chairwoman) was just able to take our issues off the table in the negotiations and leave us alone. We stepped away and were very thankful for it." ^{ciii}

By 1990, HMOs had become large and strong enough to promote actively a deregulation agenda, casting one of two dissenting votes in a special commission on health financing report that recommended the development of a Maryland style regulatory structure as the successor to the failed Chapter 23 rate setting model. ^{civ} With the arrival of the market oriented Weld Administration, HMO leaders were the first and most active interest in promoting deregulation among business groups, in the media, and in other venues. Partly, this was done out of fear that a Maryland style regulatory model would end their existing leverage in negotiating discounts. But HMO leaders also recognized that deregulation was contrary to their own self-interest in comparison to the Chapter 23 model which gave them bargaining flexibility that their rivals lacked:

"We were helped overall (by the regulatory system) because it crippled our competitors." ^{cv}

Nine of 15 Massachusetts interviewees mentioned HMOs as key deregulation advocates, more than any other group outside of the Weld Administration. But the effect of HMO support was not to bully or cajole legislators with political pressure, but rather to provide assurances that deregulation would not lead to a worsened health system crisis:

^{ciii} Interview with Robert Hughes, Exec. Dir., Mass. Assn. of HMOs, Boston, 12/15/94.

^{civ} Special Commission on Health Care Finance and Delivery Reform, Dec. 31, 1990

^{cv} Interview with Robert Hughes, Exec. Dir., Mass. Assn. of HMOs, Boston, 12/15/94.

“There was sufficient critical mass in the HMO community to allow members of the Legislature to feel comfortable because so many constituents were already outside of the (rate setting) system. It increased the comfort level ... In terms of political support (to legislators and the Governor), my groups are pathetic. I wish they would give just half as much more.”^{cvi}

In New Jersey, Department of Health officials determined in the late 1980s that they lacked legal authority to prohibit the negotiated discounting that was widespread and further undermining the integrity of a badly damaged system.[^] The President of the New Jersey Business & Industry Association testified before a legislative hearing on its effects:

“I know of a specific hospital who recently agreed to a 25 percent discount for US Healthcare. I’m under the impression that in a Blue Cross survey of hospitals, of the 83, that 73 responded indicating, ‘yup, maybe we’ll give a discount, too’ ... Of course, that discount means that I’m getting stuck even harder. So that’s the present system. That’s a disastrous system. You have a hospital rate setting commission saying, ‘this is what the rates should be.’ Right? Nobody pays it.”^{cvi}

Unlike in the other three subject states, HMOs were slow to develop in New Jersey, which was still below the national average in managed care penetration during the 1992 deregulation debate. In the course of that debate, the State’s HMO association participated in the New Jersey Coalition for Health Care Reform activities, but they also knew their proper place:

“HMOs were just part of the crowd. We realized the system wasn’t that great. But we were just coming into our own and were not a significant part of the market. The issue (deregulation) just didn’t arouse much passion.”^{cvi}

New York’s current position most clearly resembles that of Massachusetts, where HMO growth and legally authorized discounting have substantially undermined the

^{cvi} Interview with Robert Hughes, Exec. Dir., Mass. Assn. of HMOs, Boston, 12/15/94.

^{cvi} Testimony of Bruce Coe, Pres., NJB&I Assn., Assembly Health Committee, March 5, 1992

^{cvi} Interview with Dale Florio, Legis. & Reg. Counsel, NJ HMO Assn., Trenton, 4/17/95.

rationale for continued rate setting, as had the financial instability facing both the State Medicaid program and the Blue Cross plans. As was true in Massachusetts and New Jersey, HMO leaders in New York understand that their sole ability to discount actually puts them in a competitively advantaged status and in a philosophical dilemma:

“We are winners (under NYPHRM). The ability to negotiate rates, while fair, represents a major advantage for us over our competition. The Conference (of HMOs) would not fight it, and would support deregulation as a matter of principle. We certainly couldn’t oppose it. We would rather see it given to others than to have it taken away from us.”^{cix}

In evaluating the overall impact of HMOs on the deregulation process, we are faced with a puzzle. The State where HMOs have the greatest rational incentive to push for deregulation is Maryland, where discounting is not allowed, but also where deregulation is not on the policy agenda. In the other three subject states, HMOs actually were advantaged under a rate setting model that allowed only them to have substantial discounting authority. Deregulation happened in New Jersey with only a marginal HMO market and political presence. The one state where HMOs clearly made themselves a part of the deregulation process, Massachusetts, had many other critical factors pushing policy makers in that direction.

In spite of impressive HMO growth and development in the subject states, it is difficult -- if not impossible -- to assert that their presence as interest group lobbies made deregulation happen. There is no real evidence to portray them as anything resembling a replacement cartel. Nonetheless, managed care -- which HMOs institutionally personify -- played the critical role in undermining rate setting’s stability and rationale. But this dynamic is a discussion for policy ideas in chapter six, not one about interests.

^{cix} Interview with Harold Iselin, Counsel, New York HMO Conference, Albany, 6/29/95.

Business: The business community is the first constituency that we discuss that is out of the inner-health system circle. Business is divided in numerous ways, including the basic division between big and small business, but also among different lobbying groups, different sectors and different industries. Their attention is frequently split among a variety of compelling policy issues that reach a state's policy agenda during any given legislative year.

A business embrace of intrusive and large scale regulation such as mandatory rate setting in hospitals was not a position taken casually by this interest. Instead, the business community found itself in the 1970s and early 1980s unable to respond to the ability of health providers to increase dramatically the price of their services because indemnity style, fee-for-service insurance did not permit an effective payer response. Rate setting was seen as the only viable short-term alternative to cost-based, retrospective reimbursement, and was largely welcomed by business leaders in those states that embraced it. In the interim, businesses moved to self insure, to manage care, and to initiate other initiatives to move the system to the point where overt state regulation would no longer be needed.

In Maryland, business has been a long standing, though not aggressive, supporter of hospital rate setting. The system was initiated without a major role for business, and has survived with their support. Recently, business leaders have been among the leaders suggesting that a fresh examination would be welcome. The chairman of the State's Chamber of Commerce referred to "the crisis in the regulation of health care in Maryland," referring to "overlap, confusion, costs, and delays involved in such a complex regulatory superstructure" and recommending "a new commission to study what is good and what needs to be improved in Maryland's health care regulatory system."^{cx} But the potential

^{cx} Letter from Wayne Mills, Chairman to Gov. Glendening, Feb. 6, 1995

loss to the hospital community of \$200 million if the Medicare waiver were not renewed (costs that would be shifted substantially to business payers) plays into business support:

“Our views are clouded here in Maryland because of the waiver.”^{exi}

In response to a recent Baltimore Sun article asking, “Is Maryland Hospital Regulation Outdated?”, a former business representative on the HSCRC responded, “Frankly, no better system is in sight.”^{exii}

Massachusetts business leaders were much more assertive, dating to the early 1980s, in establishing directions for hospital regulation. Indeed, the coalition able to forge consensus, the Health Care Coalition, was formed and directed by Nelson Gifford, a manufacturing CEO, and chair of the Health Care Task Force for the Massachusetts Business Roundtable. But success in the early years of all-payer rate setting in controlling hospital cost inflation did not persist:

“The forceful entrance of employers into health care politics was linked to the enactment of a series of policies, each of them supported by employers, which progressively expanded access to care for the uninsured ... Employers slid down the slope until they reached the point at which support for health care for all was a logical consequence of previous positions they had taken. The center of this story is hospital reimbursement.” [13]

One important result of the 1988 Universal Health Care Law -- which included a pay or play employer mandate and greatly expanded hospital charge authority -- was a significant business retreat from health care politics in the State. By 1991, the business community was splintered. The Roundtable had largely retreated from the stage, though they mildly supported deregulation at the behest of large Boston teaching hospitals that had become organizational members; the conservative Mass. High Technology Council

^{exi} Interview with Miles Cole, Dir. of Business Affairs, MD Chamber of Commerce, Annapolis, 6/24/95.

^{exii} Baltimore Sun, April 5, 1995

also gave rhetorical support to deregulation. Small business groups ignored the issue, continuing to work to repeal the employer mandate and to enact small group insurance market reforms.

The key business group that joined the debate, Associated Industries of Massachusetts, officially supported deregulation by the summer of 1991, but most actively participated in the debate by demanding the adoption of a system wide revenue cap on hospitals:

“Although the theory behind the Administration bill is that increased competition will keep costs down, there exists significant skepticism on this hypothesis. In fact, there is speculation that costs will increase significantly as hospitals are encouraged to increase volume to compensate for any lost revenue which might result from more competitive prices on individual services ... AIM strongly urges your adoption of a system-wide revenue cap.”^{cxiii}

AIM repeated this line of advocacy throughout the legislative process in a series of letters and bulletins to members of the House and Senate and to the media. As the final bill headed for Governor Weld’s desk, they continued to sound this theme:

“We are disappointed that the system-wide revenue cap is not included in either the House or Senate bills and we are especially concerned that hospital costs may rise substantially in the next few years without any effective ongoing mechanism to protect employers.”^{cxiv}

While the overall message from the business community was supportive of deregulation, it was mixed, and the business groups cannot reasonably be considered as leading advocacy forces behind the Massachusetts deregulation process.

New Jersey business leaders had only recently come to support rate setting deregulation in 1992. As mentioned in chapter four, New Jersey Business and Industry President Bruce Coe placed his constituency only “51 to 49” in favor of deregulation at a

^{cxiii} AIM letter to Health Care Committee, September 19, 1991

^{cxiv} AIM letter to Rep. Carmen Buell, Dec. 17, 1991

March 5, 1992 legislative oversight hearing. By the time Judge Wolin's decision came down in May of that same year striking down the State's uncompensated care pool, business representatives were ready to press the issue. Hospital officials called together a meeting of key interest groups in June 1992 to plan a strategy in light of the federal court decision and were surprised by the outcome:

"While the New Jersey Hospital Association officials only wanted to address the uncompensated care issue, we all wanted to call in the whole question about rate setting ... Business, labor and insurers viewed the Wolin decision as an opportunity to introduce more competition into the rate setting system." ^{cxv}

But the end result of the New Jersey Health Care Reform Coalition was a recommendation for a three year phasing out of the DRG system, a period of time that was unacceptable to legislative leaders and to Governor Florio who wanted -- and won -- immediate deregulation with one year of loose replacement caps. Even more out of touch was the coalition's recommendation to restore funding for uncompensated care by adding one cent to the state sales tax that had been cut only months before by the new Republican majority in the Senate and the Assembly. Labor, insurer, and business groups had entered into a coalition with the hospital community -- and it was difficult to determine who had won the better part of the bargain. But one thing very clear was that the business community was not in the front driver's seat in New Jersey in 1992 on matters pertaining to health regulation.

The business community in New York shares with its counterparts in the other states a legacy of support for hospital rate setting, and now shares with its Massachusetts and New Jersey counterparts a clear sense of a need for change:

"It served us well in the 1970s and in the early 1980s in bringing stability to the hospital sector. But now where you have such blatant examples of

^{cxv} Interview with Maureen Lopes, Sr. VP for Health Affairs, NJ Business & Industry Assn., Trenton, 4/17/95.

HMO discounting as much as 40 percent of a DRG rate, it points to the fact that prices have nothing to do anymore with the market. By allowing the system to continue, it prevents market forces from shrinking the system. Everyone says that shrinking should be done, but no one has the gumption to decide how to do it.”^{cxvi}

The business community has collaborated in coming to its position with the insurers through LICONY, and with consumer advocates through the State Communities Aid Association, along with hospitals and regulators:

“At the business council, everyone has taken a pretty responsible position, and no one has said that they want to turn their backs on the special needs. Nobody wants to throw out the baby with the bath water.”^{cxvii}

The business community will be an active voice in the search for replacement revenue sources in the post-NYPHRM era. But they have never been the dominant voice in New York health policy making. In spite of the new Republican Administration in Albany, they are expected to be one of many at the table.

In summary, business is a highly regarded player in health care politics. They are listened to, respected, and sometimes feared. There are few times in any of the four states where the ultimate decisions made by policy makers were substantially at variance with the overall positions of the business community. Their long term effect seems most evident in Massachusetts. But, once again, theirs is not the effect of a replacement cartel.

Labor: The house of Labor contains at least two distinct points of view on matters relating to mandatory hospital rate setting in the states. On one hand, labor as the representative and bargaining agent for hospital workers is advantaged by a regulatory model that provides predictability, the potential for cross-industry bargaining, and the political support of political leaders during difficult negotiations and times. On the other

^{cxvi} Interview with Ed Reinfurt, Vice Pres., Business Council of New York State, Albany, 6/30/95.

^{cxvii} Interview with Ray Sweeney, Exec. VP, HANYS, former DoH, Albany, 7/21/95.

hand, labor as a purchaser of health services has an interest in seeing the cost of health benefits held down, and in using its large number of members to wrestle the most favorable rates of payment for its dollars. Labor interests of the first kind may frequently find themselves allied with hospitals on regulatory matters. Labor interests of the latter variety frequently are found in close relationships with their state Blue Cross plans.

In recent years, both elements of the labor movement have felt their backs to the wall. Hospital workers have seen the privatization and closing of public institutions where they held jobs, and the loss of bargaining leverage and jobs in private health institutions as competitive cost pressures began to bear down on the hospital industry. Unions that bargain for health benefits have also seen new pressures as management has pressed for concessions and givebacks in the form of reduced or restructured health benefits, leading to a large number of strikes over health-related bargaining issues. Building trade unions, which purchase health services through their self-funded "Taft Hartley" plans, have faced near bankruptcy in attempting to maintain health and welfare funds in the midst of serious recessions and construction slowdowns that left large portions of their memberships unemployed.

In the four subject states, the position of the labor movement on matters involving rate setting is heavily influenced by the organizational affiliation of the key union spokespersons on health policy matters. With unions and health policy, where you sit does much to determine where you stand.

The union-as-purchaser pressures in other states have not yet surfaced in Maryland in any meaningful way. The AFL-CIO maintains a strong position of support for the HSCRC, and holds a seat on that regulatory body. The key spokesperson for the labor movement on rate setting matters is a former executive director of a local public employees affiliate of the American Federation of State, County and Municipal Employees. He is also a vice president of the Maryland Health Coalition:

"From the viewpoint of a trade unionist, we get good hospital care, at reasonable rates, and the system has an extremely positive social aspect with total equal access. The uncompensated care system is the best in the country. It's a good system, and they monitor the quality and efficiency. It's also a wide open system. You can find out anything in this system."
cxviii

In Massachusetts, health policy matters had largely been the province of leaders from the Service Employees International Union, Local 285, representing health care workers at Boston City Hospital and other key institutions. In the late 1980s, construction trade unions organized their own ambitious network of health and welfare funds, pooling their resources to bargain with hospitals, and emphasizing preventive and primary care for their members and families.

In the 1991 deregulation process, both branches of labor found common ground in legislative proposals to establish a single payer financing system, proposals that were overwhelmingly defeated in the legislative process. Hospital workers, realizing that deregulation would threaten their job stability, preferred any alternative to deregulation. Building trade unions wanted any system that represented a change from the high hospital cost inflation experienced under Chapter 23. But once single payer proposals were defeated on the floor, Labor struggled to find a real alternative to support. The official position of the Massachusetts AFL-CIO reflected that ambiguity:

"The rising cost of health coverage has been the major cause of job actions and contract disputes in the last five years ... H6280 (the deregulation bill) takes Massachusetts in the wrong direction. Deregulation of the airline and trucking industries has resulted in lost jobs, company closings, and higher costs to consumers ... We urge you to vote to defer action ..."
cxix

In fact, organized labor in 1991 had many other issues before the Legislature of higher priority to them than the fate of hospital rate setting. These included opposing

cxviii Interview with Ernie Crofoot, former AFL-CIO representative to HSCRC, Bowie, 6/22/95.

cxix Letter from Mass. AFL-CIO to Mass. House of Reps., November 20, 1991

attacks on the workers compensation system, and fighting Weld Administration efforts to privatize large segments of state government. One of Labor's key point persons in 1991 on health regulation recalls the uncertainty in the movement:

"Labor was divided. Some in construction were purchasers and provided insurance. Others want a more regulated single payer system. While labor was on the right side in terms of lobbying -- they supported regulation as opposed to competition -- did they understand the full repercussions? No ... Construction trades used to eat my head off when we talked about limits on hospital capital expansion. Suddenly people realize that there's going to be a big loss in jobs." ^{cxx}

In New Jersey, it was the building trades unions that held sway on rate setting matters. The key labor appointee to the Rate Setting Commission was the administrator of the Carpenters Fund who initiated in 1991 the federal lawsuit against the Uncompensated Care Trust Fund. That suit was in response to UCTF surcharges approaching 20 percent at a time when large portions of construction trades membership were unemployed in the aftermath of the 1980s casino building boom. While the suit is credited by all observers with triggering the chain of events that led to deregulation, the Rate Setting Commission's final labor appointee denies that ending rate setting was their goal:

"We were not looking to topple the DRG system, but looking instead to find a fairer way to finance uncompensated care. The deregulation of rate setting was not my explicit desire ... The coalition position was for less regulation, not for total deregulation." ^{cxxi}

Other key labor leaders, however, did desire to get rid of the New Jersey DRG rate setting system:

^{cxx} Interview with Celia Wcislo, President, SEIU Local 285, Boston, 1/19/95.

^{cxxi} Interview with George Laufenberg, Administrator of New Jersey Carpenters Fund, RSC member, Edison, 4/19/95.

“Our idea was to get rid of it (rate setting) because of how evil it was in manipulating the charges.”^{ccxii}

While New Jersey labor supported the recommendations of the Health Care Reform Coalition in recommending a three year phasing out of rate setting, it broke completely when the coalition chose to support the Legislative-Governor Florio negotiated package to fund uncompensated care for a three year period by raiding \$1.5 billion from the State’s Unemployment Insurance Trust Fund. When the labor movement brought their busloads of workers to the State Capital in November, 1992 to weigh in on the legislative debate, their target was the fund diversion, and not at all preserving the rate setting system for any length of time.

In New York, the labor movement is currently silent and non-engaged in debates about NYPHRM’s future. This is unexpected in light of the generally held view that hospital worker unions are key beneficiaries of the NYPHRM system. The loss of rate regulation will hold significant ramifications for organized labor:

“A regulated environment and labor negotiations go hand in glove. Regulation gives organized labor the ability to get things that they couldn’t get in a non-regulated environment. The structured payments, the predictability, the lack of volatility, the homogenous solutions that apply to all institutions. Once you figure out the wage rates, it’s across the board. So 1199 (the hospital workers union) can structure agreements with groups of institutions which are cross employer. They can achieve multi-institutional bargaining units. The League of Voluntary Hospitals across the hall from here do bargaining with 1199 for about 40 hospitals. Their deals apply across the industry. In addition, the unions have a history of running to the politicians when they get or think they get a bad deal as another way to leverage the industry. The competitive markets are hostile to organized labor. Under competition, one institutional situation will not be replicated at another.”^{ccxiii}

^{ccxii} Interview with Charles Marciante, President, New Jersey AFL-CIO, Trenton, 4/18/95.

^{ccxiii} Interview with Kenneth Raske, Pres., Greater New York Health Care Association, New York City, 7/20/95.

One New York labor official put the same point of view more succinctly:

“Labor doesn’t like change.” ^{xxxiv}

Nonetheless, as was the case with labor leaders in Massachusetts in 1991, New York unions now appear to find other fights over the future of the New York City municipal hospital system, the direction of Medicaid managed care, and other battles as more central to their interests than the future of NYPHRM. As of the writing of this study, labor has yet to weigh in on the future of hospital rate setting at a time when most informed minds have already been made up that rate setting will go.

Once again, we cannot see any pattern suggesting that the labor movement has had a disproportionate impact on the fate of hospital rate setting in the various subject states. With the exception of Maryland, their response to deregulation pressures has been ambiguous.

Consumers: “Democratic governments tend to favor producers more than consumers in their actions,” notes Downs in discussing the reasons why the presumed beneficiaries of regulation have so little input into the processes that create the structures. [14] Olson posits that in the absence of selective incentives to individuals to act, “the incentive for group action diminishes as group size increase so that large groups are less able to act in their common interest than small ones.” [15] Gormley has observed that issues high in technical complexity (such as public utility regulation and, certainly, hospital rate setting) are likely to discourage grassroots consumer participation, while issues that are highly conflictual will discourage the involvement of “proxy advocates” acting in their behalf. [16] Feldstein suggests that the lack of consumer involvement makes sense because the increased prices that must be paid to sustain regulatory structures do not

^{xxxiv} Interview with Debbie Bell, Coordinator of Policy Development, DC 37, AFSCME, New York City, 7/20/95.

outweigh the costs of the personal involvement in changing the structures; consumers have a "diffuse" interest in regulatory matters that reduces their incentive to engage in regulatory politics. [17]

One way to address the need for consumer participation is to require it in statute. But this solution is itself no panacea. Vladeck examined the federally mandated role for consumers in the health planning initiatives of the 1970s, and concluded that Congress naively adopted a pluralist, interest-group representation model that they thought would bring all affected parties effectively into the fray. Instead, he found log-rolling, bargaining, and collusive competition among narrowly defined special interests who often identified themselves as representing broader consumer concerns, while the interests of the public were less well served. [18] Alternatively, none of the state rate setting models in this study mandated any direct consumer involvement in decision making.

As is true with labor, a consumer's interests regarding rate setting depend significantly on that individual consumer's own position. An uninsured individual's ability to obtain necessary hospital care because of generous reimbursement for indigent care would make that person a winner as compared to a person in states without such support - unless that same money were used to purchase insurance coverage for uninsured persons, such as in Minnesota, in which case the same person could be called a loser. An individual insured under a traditional fee-for-service indemnity policy might also be considered a winner because rate setting systems were able to hold down the rate of increase in hospital charges -- at least for some periods of time in some of the subject states. An individual in a managed care plan could potentially be considered a loser in Maryland because the plan could negotiate lower rates of payment without rate setting; but an individual in a managed care plan in the other three subject states might actually be a winner because of their plan's significantly lower hospital rates relative to other payers.

In Maryland and New Jersey, organized consumer involvement at any stage during the decades long history of their rate setting programs was largely non-existent.

Interviewees in both states were unable to identify an organized consumer presence that directly involved itself in the details of rate regulation. Some general interest organizations such as the League of Women Voters, church-affiliated organizations, and senior citizens groups would speak out on broader health matters, but not in a way that affected the direction or shape of rate setting regulation. The author was not able to identify a single consumer representative who was knowledgeable about the intricacies of these complicated systems. The voices of consumers were heard in New Jersey in the form of constituent complaints about discrepancies on their hospital bills between listed charges and DRG state-approved charges. These complaints had a serious impact on legislators in both parties in an unorganized but highly effective fashion. Consumer voices also were heard in 1995, for example, when these two states became the first in the nation to seek to outlaw “drive through deliveries” and to regulate hospital maternity stays. Once again, unorganized voices occasionally also have a means to be heard.

In contrast, Massachusetts and New York had and sophisticated consumer advocacy groups involved in rate setting and other issues concerning health care finance and insurance. In Massachusetts, Health Care for All, funded through grants and grassroots support, has been a respected voice in health care issues since the mid-1980s, particularly with the news media. They maintain both a professional staff and a citizen membership. In the 1991 deregulation debate, they unsuccessfully opposed the move toward a competitive system, and supported the union backed single payer alternative:

“The Health Care Committee’s bill contains even fewer cost containment provisions and less money for access programs than the Weld bill does. The ‘competitive strategy’ is not a new idea. It has been tried in other states without success. It has failed to address adequately the cost problem facing our health care system and has only made access problems worse.”

ccxv

While not able to achieve their objectives in stopping deregulation or establishing an alternative financing mechanism, the group established alliances with sympathetic academics from the Harvard School of Public Health, the Boston University School of Public Health, and the Brandeis Heller School for Social Policy that established a level of debate and dialogue about health system direction that otherwise would have been missing in the contest of interest groups. This aspect of their role will be discussed and analyzed more fully in chapter six.

In New York, the key consumer organizations are the low income advocacy organization, the State Communities Aid Association, and the grassroots activist organization, Citizen Action. Their perspectives are markedly different. The former has moved from a position of dependable support for regulation to vocal support for deregulation. Their executive director has taken strong public stands, and has formed alliances with both the Business Council of New York State and the Insurance Industry in advocating a move away from NYPHRM:

“We initially were very strong supporters of the NYPHRM concept. Back in 1983, we were one of the organizations to initially endorse the so-called Medicaid/Medicare waiver that enabled Medicare to participate in NYPHRM ... However, over a period of time, and this wasn’t an instant conversion, we started to see growing problems with NYPHRM ... Despite having a mechanism like bad debt and charity care, voluntary hospitals were diverting patients away from their door to public hospitals.” ^{ccxvi}

Citizen Action has been less directly involved in the NYPHRM debate, but has been very much a part of health care access and financing debates, strongly pushing single payer legislation that actually passed the New York Assembly in 1991, promoting prior

^{ccxvi} Interview with Gerry Billings, Executive Director, State Communities Aid Assn., Albany, 6/30/95.

DoH experiments with hospital global budgeting during the Cuomo Administration, and promoting restrictions on the practices of the managed care industry.

Needless to say, there's nothing like a cartel to be found here. None of these organizations have the financial, organizational, or political clout to dictate the results of health policy debates -- on rate setting or any other hospital finance or insurance matters. But these groups do add genuine substance to debates that otherwise can focus entirely on interest group politics and insider issues. The role of these groups will be explored in more depth in chapter six.

State Administrations: There are at least four distinct and important viewpoints from the state governmental perspective that must be considered in examining that sector's role in rate setting policy decisions: those of chief executives, legislators, rate setting regulators, and health purchasing agencies such as Medicaid. The particular perspectives and actions of chief executives and of legislators will be examined more closely in the chapter six discussion of policy ideas.

While chief executives and legislators have been with us throughout modern history, the other two state governmental entities are much more recent in their appearance. Tierney observed that the growth of Medicare and other health entitlements had worked to alter fundamentally the role of government and government agencies in health politics and policy making: "the federal government has become the nation's largest single source of payment for health care and, thus, is a primary actor with interests of its own. ... far from being paralyzed, the government is now the driving force in health policy making. The government's information, stakes, and preferences -- in short, the government's interests -- now increasingly define the interests of private groups, not the reverse." [19] This section seeks to analyze the behavior of both the rate setting regulators who set the rules and run the prospective payment system as well as the

government health purchasers who often run into conflict with the former group and whose influence and authority have increased along with their budgets.

State Government as Regulator: The political influence and role of regulators has been considered and debated by numerous policy analysts. Niskanen, whose ideas are influenced by the theory of economic regulation and rational choice theory, views bureaucracies such as rate setting commissions as independent actors and interest groups in their own right. Developing his theory of bureaucratic behavior, he predicts that agencies will mostly seek to increase their budgets as much as possible, and that both legislators and chief executives will be unable to judge the true need for agency resources because of information problems. In short, regulatory agencies become an interest unto themselves, imperialistic, expansionist, in search of more resources and authority. [20]

Wilson, in particular, takes issue with the Niskanen theory, citing example after example where federal, state and local agencies resisted legislative and executive branch invitations to expand the scope of their operations: "...they (bureaucrats) cannot put any surplus revenues into their own pockets; their salaries do not increase with the size of the budget ... and now it even appears that they cannot even expect to occupy big offices with thick rugs on the floor and a nice view of the city ... the political environment in which they work powerfully inhibits them from converting their management of a bureau into material gain ... The truth is more complicated." [21] Noll reached a similar conclusion in examining budget theories that suggest that agencies want primarily to maximize their own budgets: "In the case of regulatory agencies, the theory does not seem to work." [22]

Gormley, examining the authority and capacity of public utility regulators, found "people who differ markedly in their party affiliation, professional background, and industry experience. Many differ in their attitudes as well." While more independent of gubernatorial and legislative authority than often recognized, regulators responsiveness to the public and interest groups will vary from issue to issue and from agency to agency

depending upon the local political culture, the issue complexity and level of conflict involved. [23]

The evidence from this study lends support to the Wilson, Noll and Gormley viewpoints. In Maryland, the Health Services Cost Review Commission dominates the rate setting policy discussion because of the trust and broad degree of regulatory discretion that legislators and executive branch officials have placed in them:

“They (HSCRC) are truly expert at what they do. There’s a lot of trust that policy makers have put into that Commission. The Planning Commission gets a somewhat different response.” ^{cxcvii}

Far from being its own special interest, the HSCRC leadership remain highly attentive to the needs and desires of governmental and non-governmental players, adapting the regulatory model to the health market changes needed to sustain the system. Neither their offices nor their scope of regulatory authority have grown. Indeed, when legislators decided to expand the scope of state regulatory authority to physicians and their costs, a new Commission, the Health Care Access and Cost Commission, was created to address that policy objective instead of assigning the new job to the HSCRC.

The most pointed recent criticism of regulators concerns conflicts among the three commissions with regulatory authority over the health system, the HSCRC, the Health Care Access and Cost Commission, and the Health Planning Commission:

“There are personality conflicts between the agencies that have inhibited their ability to cooperate. The bottom line is that there are two ways as to how one might go about regulation -- through a highly centralized regulatory body, or the Maryland way through a decentralized structure.” ^{cxcviii}

^{cxcvii} Interview with Sen. Paula Hollinger, Chairman, Senate Health Care Committee, Annapolis, 6/20/95.

^{cxcviii} Interview with Larry Lawrence, Exec. VP, MD Hospital Assn., Lutherville, 6/21/95.

The Maryland legislation approved in the 1995 session calling for an examination of Maryland health sector regulation also required the three health regulatory agencies to develop a more collaborative working relationship. The most important changes in regulatory activity involve the experiments with capitated forms of regulated payments, described in chapter four. Overall, the interests in the Executive Branches of the other states in moving away from hospital rate setting are not in evidence in Maryland.

In Massachusetts, the regulators in charge of the rate regulation program were located in the Rate Setting Commission, a separate entity within the Executive Office of Health and Human Services. Rather than assume their own independent outlook, RSC leaders followed policy directions laid down to them from the Governor and the Secretary of Health and Human Services. This occurred across successive Administrations, regardless of party or regulatory outlook. When Dukakis officials sought tighter controls on hospital spending in the mid-1980s, RSC officials provided the analyses and backup to document their case; when Weld officials sought to trigger the deregulation process in 1991, RSC officials wrote the initial legislation that put their 15 years of rate setting authority out of business. When the Legislature moved for a faster demise to rate setting authority, the agency quietly complied:

“When House Ways and Means came out with a draft that deregulated more than the Governor’s bill and took a complete deregulatory approach, it became clear that the Administration would not push back from that.”

ccxix

Bureaucratic rivalry and turf protection existed in Massachusetts between the RSC and the Medicaid program over rate approval authority, a battle that was won finally by the purchasing agency in 1991. Again, there is no evidence of Niskanen-like behavior as regards the Massachusetts Rate Setting Commission and the rate setting program.

^{ccxix} Interview with Paula Griswold, former Chairperson, Rate Setting Commission, Boston, 12/23/95.

In New Jersey, the activities within the Administration were also complex. A series of governors dating back to Marvin Mandel in 1971, and including Republican Thomas Kean in 1981, supported the development and evolution of the rate setting model and the Department of Health's regulatory role. As we saw in chapter four, DoH officials played an aggressive and far-reaching role in the establishment of New Jersey's DRG payment model, a role that comes closer than any other we have seen to Niskanen-like behavior. But the regulatory innovators who designed and implemented the new model left New Jersey state government almost as quickly as they arrived, leaving the system in the hands of long time civil service employees.

Rather than an agency attempting to satisfy their lust for budget authority and power, the New Jersey regulators seemed much more to be overwhelmed with the complexity and difficulties of their task, literally throwing up their hands in 1991 and giving about \$1 billion in retrospective rate setting charge adjustments to the hospital industry. Members of the Commission seemed as befuddled as the general public in observing these developments:

"Rate setting was not working very well. It was more like a rubber stamp of whatever the hospitals wanted. I don't recall any hospital having a difficult time getting rates increased. There were five commission members and a staff of three. The Department of Health used up other funds for back up services like transcripts. We couldn't address the issues as an independent group because we had to rely on DoH. It was always last minute decisions and a sense of urgency. At one time we were changing hospital factors on a monthly basis. The hospitals became very effective in gaming the system."^{xxxx}

When deregulation became an obvious part of the policy agenda in the fall of 1992, then DoH Commissioner Bruce Siegel walked a fine line convincing supporters and

^{xxxx} Interview with George Laufenberg, Administrator of NJ Carpenters Fund, and former RSC member, Edison, 4/19/95

opponents of rate setting alike that he was on their side.^{cxxxi} The Rate Setting Commission that was housed within the Department of Health played no significant role in fighting the rate setting deregulation. When the decision came for rate setting deregulation, the bureaucracy that has run the system was left out of the room and out in the cold.

New York's Department of Health bureaucracy that managed the five versions of NYPHRM was large, stable, and powerful. Indeed, hospitals were often characterized as needing to travel to Albany, hat in hand, seeking favors and dispensations from the DoH Commissioner and bureaucrats. Nonetheless, it is also apparent that the Legislature dictated NYPHRM reimbursement rules and formulae that were often at variance with the desires of the health bureaucracy. There is also no evidence that the Department varied from the policies and imperatives laid down by the Rockefeller, Carey, and Cuomo Administrations over 25 years of rate setting policy. Perhaps most illustrative of the fragility of such seemingly strong bureaucratic institutions is the speed with which the NYPHRM bureaucracy fell apart with the election of George Pataki as Governor in 1994.

The four sets of bureaucracies described in this section varied widely in terms of size, authority, stability, and effectiveness. Rather than viewing them in Niskanen terms as a separate interest, pursuing their own self interested agendas, and seeking to maximize their own resources and budgets for their own purposes, Wilson's comment returns as the most appropriate summary: "The truth is more complicated." [24]

State Governments as Purchasers: Ever since state governments became major financiers of health services through the creation of the Medicaid program in 1965, they have assumed an interest that goes well beyond the traditional crafting of public policy through legislation and regulation. States originally were compelled to finance Medicaid

^{cxxxi} Five New Jersey interviewees offered different impressions of Commissioner Siegel's position on deregulation. Efforts to interview Commissioner Siegel for this study were not successful.

services through retrospective, cost-based reimbursement at the inception of the new program. Beginning in the 1970s, the federal government actively encouraged states to experiment with different financing models that would more effectively constrain the growth in both Medicaid and Medicare. As we have seen, our four subject states were among the pioneers in experimenting with innovations in prospective payment and other kinds of regulation.

But the rapid escalation in Medicaid costs, along with growth in the use of managed care in Medicaid programs, and finally accompanied by dissatisfaction with the effectiveness of hospital rate regulation, led state government officials to begin to assume different roles in relation to the health sector in the late 1980s. State Medicaid officials have moved from being mere payers of hospital, physician and other health provider bills to being active and aggressive purchasers of health services, with clear outcomes and standards. It is this evolution, as much as any other factor, that pushed the subject states to reassess the role of hospital rate setting. It is the growth in the role of state government health purchasing entities that has transformed the role of the state in relation to health providers and health interests.

In Maryland, managed care for Medicaid is a recent phenomenon. Rivalry between Medicaid and the HSCRC has not been an issue for bureaucrats or for legislative and executive branch policy makers. The value of the federal Medicare waiver provides a strong disincentive for policy makers in any branch of state government to back abandonment of the system. Finally, the apparent ability of the rate setting system to hold down the growth in hospital charges provides an additional discouragement to those inside government who would seek another financing structure for hospital care. Interviewees in the Senate, the House of Delegates, and the Department of Health frequently defer to the Health Services Cost Review Commission leadership in discussions about the future of the system. Though the rapid growth in Medicaid managed care may lead to a shift in attitude

on the part of policy makers, the current lack of conflict is one more example of how Maryland has found a way to make rate setting work in the current volatile environment.

In Massachusetts, rate setting began because of the Medicaid financial crisis of the mid-1970s. While the state program was affected by rate setting decisions in subsequent years, its officials did not play a significant role in rate regulation decisions throughout the 1980s. The subsequent Medicaid crisis in the early 1990s played an important role in precipitating rate setting's demise. With plans for a major Medicaid managed care program developing rapidly in the early 1990s, the linkage of Medicaid hospital payments to a dysfunctional charge structure was viewed as a key reason to abandon rate setting:

"Medicaid was not the sole reason for (deregulation). But to the extent that Medicaid was a payer, what really drove the change was the interest of the payers and the changes occurring in hospital finance generally ... In Medicaid's case, we really didn't have control over what we were paying."
cxcvii

Rivalry between Rate Setting Commission and Medicaid officials was common during the late 1980s and early 1990s, as Medicaid sought to control its own financial destiny. While Rate Setting bureaucrats won a number of the turf battles in the late 1980s, Medicaid officials won the major battles during the deregulation process because of extraordinary budget increases facing their program, and because Medicaid officials' positions were consistent with those of other important interest groups such as Blue Cross and the HMO community.

In the history of the New Jersey DRG system, Medicaid purchasing decisions had not been a major factor. That began to change in the mid to late 1980s when the DRG system began to become more and more dysfunctional. Even though New Jersey Medicaid program officials were not aggressive in moving to implement managed care,

cxcviii Interview with Bruce Bullen, Commissioner, MA Dept. of Medical Assistance, Boston, 1/4/95.

they came to believe in the late 1980s that the DRG program was wasteful and inefficient, and led to excessive Medicaid payments to acute hospitals that were beyond the agency's ability to control. Tensions became apparent between the Medicaid program and the DoH that reached into Governor Florio's office in 1991. The Governor and his staff sided with Medicaid, giving it a greater payment differential to reduce its acute hospital expenditures. [9]

In the years leading up to Judge Wolin's May, 1992 decision, Governor Florio and his key health staff person, Brenda Bacon, became increasingly disenchanted with the DRG program, and seized upon the Judge's decision to place deregulation squarely on the State's agenda. While concerns about the usefulness of the DRG system were foremost in the Governor's mind, concerns about the impact of the system on the State's health purchasing systems was also an important concern as the State continued to grapple with the economic recession of the early 1990s.

New York's NYPHRM model was most frequently characterized by consensus decision making and collaboration during the five legislatively enacted versions, even though disagreements and confrontations occurred. A high degree of cooperation characterized decision making among legislative leaders, the Governor's staff, the Department of Health leadership, and the rate setting regulators. Because Medicaid had not moved forward on managed care until the early 1990s, tensions between that program, housed in the state Department of Social Services and rate setting were not substantial.

The strong pressure to move Medicaid into a full managed care system has shifted fundamentally the attitudes toward continued rate setting in New York. The consensus that held NYPHRMs I-V together now has been replaced by an equally strong consensus that the time for mandatory hospital rate setting has passed. Central to this is the emergence of purchasing rather than regulation as the critical state governmental need. The decoupling of Medicaid and Blue Cross rates in the spring of 1995 is the most tangible evidence of the change to date, but much more will occur during the 1996

legislative session. The challenge now for New York policy makers is to preserve the key health care access elements that have been built into the NYPHRM financing model over the past 14 years:

“What’s really so daunting about the task is that it took 12 to 16 years to build up a whole system of health care financing. And it’s all converging in one legislative session and in one six month time period. And undoing any piece is going to have a profound impact on other pieces. I look at this as a set of dominoes.” ^{cccciii}

Summary Comments on Interest Groups: Most apparent from this survey of key rate setting interests is that -- with one important exception -- each set of interests had its wins and its losses. At one time or another, they were all able to influence the shape and direction of hospital regulatory policy in important ways, and some more than others.

The one entity that most frequently got what it wanted was state government, in the form of the State’s health sector purchasing (chiefly Medicaid) needs, backed up by both the executive and legislative branches. In fact, it is reasonable to conclude from this summary that unlike every other group, the state *always* -- or nearly always -- got what it wanted. Shown below is another version of the Chart 5.2 that shows State Government’s experience under rate setting, instead of that of the hospitals: (+ indicates an attainment of objectives; - indicates failure to achieve objectives; 0 indicates a mixed bag)

Table 5.3: State Government Experience Under Rate Setting

	Birth	Growth	Maturity	Decline/Revival
MD	+	+	+	+
MA	+	+	0	+
NJ	+	+	0	+
NY	+	+	+	+

^{cccciii} DoH Commissioner Barbara DuBuono, in Empire State Report, October, 1995

Even in those periods when hospitals were particularly successful in winning large infusions of financial resources (particularly during the maturity stages in Massachusetts and New Jersey), it is clear that state legislators made conscious policy decisions to direct more money to hospitals to compensate for over-tightening in prior regulatory periods. Even huge policy direction changes, such as support for deregulation in Massachusetts, New Jersey, and New York must nonetheless be characterized as wins for the Administrations and legislative leaders that pushed for and won these changes in the face of mixed or uncertain positions by many key interests. A key and continuing concern for state policy makers was for the health purchasing needs of government. Rate setting programs were initiated largely to protect the interests of the state as purchaser, and were abandoned because of a changed approach by those same purchasers.

But is state government, thus, our elusive cartel as outlined in the theory of economic regulation?

Not by a long shot. There is simply no support in the literature relative to the theory of economic regulation that would allow for government itself to become the cartel. In fact, the suggestion distorts the fundamental characteristic of the model, in which legislators, regulators, and governors are directed by the regulated industry and are merely ciphers seeking re-election and job security, aided by cash, volunteers, and support from ready and willing interest groups. There is even less support for the Niskanen hypothesis which suggests that the regulators themselves become an independent and overly-powerful interest group. The health purchaser functions of state government have grown in power and influence, but with the active direction, encouragement and support of legislative and executive branch officials, not at all on their own.

It can be argued that state government, in its multiple roles as purchaser, policy maker, and regulator holds too many of the cards for the public's or its own good. This observation would be most in sync with Tierney's conclusion that "government is now the

driving force in health policy making.” [25] But that suggestion is the research question for another study.

Now we will examine the specific hypotheses presented at the start of this study relative to the theory of economic regulation.

Examination of Theory of Economic Regulation Hypotheses

Presented below is a table summarizing findings from each state (and overall) for each of the hypotheses specified in the theory of economic regulation model:

Table 5.4: Theory of Economic Regulation Hypotheses and Results

	MD	MA	NJ	NY	Overall
E1: Rate Setting should benefit hospitals more than consumers.	NO	MIXED	YES	MIXED	MIXED
E2. Shifts in the configuration of interest groups supporting rate setting should accompany deregulation.	-	YES	YES	YES	YES
E3. Shifts in interest group support should not be observable in Maryland.	MIXED	-	-	-	MIXED
E4. Elected officials should play only a secondary role, with interest groups leading the agenda.	NO	NO	NO	NO	NO
E5. Identifiable shifts in overt political support from interest groups to key legislative leaders should be identifiable.	NO	NO	NO	NO	NO

Evidence explaining the conclusions for each hypothesis and for each state will be presented in turn.

E1: Rate Setting regulation should benefit hospitals more than consumers.

Maryland: There is evidence to suggest that hospitals have been the principal beneficiaries from the Maryland rate regulation system going back as far as 1971 when the original enabling legislation was written in MHA headquarters with the specific purpose of pre-empting more intrusive federal rules that were wrongly anticipated. The selection of a

hospital CEO as the first chairman of the HSCRC adds further weight to this argument. The fact that inpatient admissions in Maryland declined much more slowly than in the rest of the nation between 1982 and 1992 (Maryland's position among the 50 states rose from #42 to #24) suggests that this system helped to prop up an unnecessary level of hospital business.

But these points are overridden by strong counter-evidence. It is fact that: 1) growth in charges per admission have been lower than the national average for 19 of 20 years; 2) per capita hospital growth between 1980 and 1991 was 47th among the 50 states; 3) length of stay dropped between 1982 and 1992 from #11 to #36; and 4) the operating margins of Maryland hospitals have been consistently lower than margins for acute hospitals nationally. All of these facts strongly contradict the assertion that hospitals won out at the expense of consumers. The numerous lawsuits facing the system from the hospital community during its early years that were won by the regulators provide further evidence, and also in the fact that the trustees who were newly in charge of the MHA in 1971 explicitly wanted a prospective alternative to retrospective, cost based reimbursement. This conclusion does not suggest that consumers will always be beneficiaries, especially in a new managed care environment. But for now, the evidence strongly contradicts the hypothesis. *(NO)*

Massachusetts: Data suggest that between the years 1976 and 1987 the system under Chapters 409, 372, and 574 actually reduced the rate of growth of inpatient costs per admission relative to the national average. Indeed, Massachusetts per capita hospital cost growth was 42nd among the 50 states between 1980 and 1991 -- even though the years 1988 to 1992 were ones of hyper-hospital inflation. Also clear is that Medicaid cost control was a key motivation for the establishment of rate setting, and that -- unlike in New Jersey -- Mass. policy makers moved quickly to place tight controls on the growth in the uncompensated care pool over hospital objections.

Evidence supporting hospitals as the winners include: 1) the extraordinary growth in hospital costs during the Chapter 23 period when the bottom fell out of the rate setting system; 2) Massachusetts remained number *one* among the 50 states in per capita health and hospital costs in 1972, 1982, and 1992; 3) the federal Medicare waiver was abandoned as soon as -- and only when -- the hospital community decided to give it up. There is convincing evidence on both sides. (*MIXED*)

New Jersey: There is evidence that both the SHARE program and the DRG program in its early years through 1984 were successful in holding down per admission costs below the national average. But on the other side, the evidence is strong that the New Jersey program epitomized regulatory failure: 1) an extraordinary growth in charge control authority in the final six years, including retrospective settlements where regulators simply threw *up* their hands and threw *at* the hospitals more than \$1 billion; 2) New Jersey's rank among the 50 states rose from #27 in 1972 to #5 in 1992 in per capita health costs, and from #30 in 1982 to #16 in 1991 in per capita hospital costs; 3) the state's rank in per admission costs rose from #23 in 1982 to #15 in 1992; 4) the drop in admissions was far less than the national average, and the state's rank rose from #30 in 1982 to #10 in 1992; 5) added to this was an extraordinary growth in the surcharges tied to the uncompensated care pool, nearing 20 percent in 1991. (*YES*)

New York: Evidence supporting consumers as winners includes the following factors: 1) hospitals faced two major periods of deep financial crisis during the rate setting years, in the late 1970s and 1980s, both the result of aggressive cost containment policies pushed by the State; 2) per capita hospital growth between 1980 and 1991 was only 33rd in the nation among the 50 states; 3) New York hospitals have consistently had the lowest operating margins in the nation during the rate setting years, and the State has consistently made Medicaid cost control a central driver in its health system decisions.

Supporting hospitals as winners: 1) only \$4 of every \$10 going to uncompensated care pools actually went for indigent care in the early 1980s; 2) per capita hospital costs,

per admission hospital costs, and average length of stay have consistently been among the top four of the 50 states throughout the 1980s and 1990s; 3) the drop in admissions was far less than the national average, with the state's rank rising from #29 in 1982 to #15 in 1992. The evidence to grant the state a fuzzy grade is clear: *(MIXED)*

Summary: As has been stated before, hospitals had their wins and losses. Rate setting systems have seen periods of strict and loose financial controls. Evidence strongly suggests that consumers were losers in New Jersey, and winners in Maryland. It is just not as clear in Massachusetts and New York. *(MIXED)*

E2: A shift in the configuration of interest groups supporting and opposing rate setting's continuation should accompany deregulation.

Massachusetts: The clearest switch was observable in the executive branch with the transition from Governor Michael Dukakis to Governor William Weld on downwards, including the Secretariat of Health and Human Services as well as the Medicaid program. Mass. Blue Cross had been a long term supporter of rate setting, but joined the opposition when it became apparent that a Maryland-type model that would end HMOs right to unlimited discounts was not in the offing. The business community moved more slowly, and hedged its support for deregulation with calls for ill-defined global caps, but was clearly counted in the column supporting deregulation. The HMOs were not part of the original rate setting coalition, but strongly pushed for deregulation as newly formidable players. Some hospitals, especially large and powerful academic medical centers, were strong early supporters for deregulation; the MHA waited to see the likely direction, and followed rather than led, but clearly did not push for continued regulation. *(YES)*

New Jersey: Again, the clearest switch involved the Administration, as Governor Florio became a strong advocate for dropping the DRG model, along with his key health policy aid, Brenda Bacon, and the Medicaid program; the DoH stance was non-committal on continuing its own program. The hospital industry literally divided itself over the issue, with suburban and community hospitals promoting deregulation, while urban and

teaching institutions strongly worked against the plan. The insurance community -- including Blue Cross, commercial plans such as Prudential, and HMOs -- all wanted to move away from rate setting with its burdensome and unpredictable retrospective settlements. The business community changed its position in the spring of 1992 to favor deregulation. Most unusual among the subject states, the New Jersey labor movement placed itself squarely on the side of those seeking to dismantle the system. It is noteworthy that the non-governmental interests all defined deregulation as a three-year transition out of the DRGs, and that the governmental players -- Governor Florio and the Legislature -- moved for the sharper break. (YES)

New York: The change in support for NYPHRM starts at the top, with newly elected Governor Pataki and his Commissioner of Health, Barbara DeBuono who has been leading the process to find acceptable replacement revenue sources for the parts of the rate setting system to be salvaged. The hospital industry, as in New Jersey, appears sharply divided over NYPHRM's fate, with Long Island and New York City institutions promoting continuation, and upstate hospitals looking toward a market future. The insurance community, including Blue Cross, the commercial payers, and the HMOs, are all strongly on record in support of deregulation. Business has weighed in to support deregulation, a change from its long term support. Labor is strangely silent. The unique development is the strong deregulation advocacy by the low income consumer group, the State Communities Aid Association, which has a long history of NYPHRM support. (YES)

E3: Shifts in the configuration of interest group support for regulation should not be observable in Maryland.

Maryland clearly does not exhibit the sharp changes in the interest group landscape that appeared in the other deregulated states. However, a close examination reveals a series of subtle shifts that produce a more clouded picture, chiefly in the business and insurance industries. The business leadership has clearly sounded its intention to open a dialogue on the future of hospital rate regulation in the State, and is talking about the

changes in the State's environment wrought by the strong emergence of HMOs. The Chairman of the State Chamber of Commerce used the word "crisis" in his letter to Gov. Glendening calling for a "fresh" look at the regulatory structure.

In the insurance community, Blue Cross has always had an ambivalent attitude toward Maryland rate setting, a stance very much in evidence today. But commercial insurers, who have been long and vocal supporters, now openly question the need for rate setting in the managed care environment -- and privately admit that all their key companies would like to see it go. The HMOs, similarly, will not call openly for abandonment, but clearly indicate dissatisfaction with its restrictions. In Maryland as in other states, fissures are also in evidence in the hospital community, with suburban hospitals talking quietly but openly about the need for a less heavy-handed approach and an ability to compete on a more even footing with the new players such as the one-day surgical centers.

All of these groups have been stopped in their tracks by a strong resistance on the part of the Legislature, hospital leadership, and the HSCRC/DoHMH bureaucracy to suggestions of deregulation. Thus far the Legislature's stance clearly has prevailed. But, equally clear is that the ground is beginning to shift. (*MIXED*)

E4: Elected Officials should play only a secondary role in decisions about rate setting and deregulation, with interest groups leading the agenda.

Maryland: The key health policy leaders in the House and Senate do not want to shut out any dialogue about the value and direction of the rate regulation system. But they make it abundantly clear that Maryland's unique model fits well with the state's values and political culture, and that they will fight hard to keep it if that becomes necessary. Thus far, the administration of Gov. Glendening has issued the same signals, though the Governor himself has not become directly involved. The leadership of the HSCRC is proactive in its work, seeking to forge consensus within the current policy framework, and allowing experimentation that does not undermine the basic structure.

Rather than suggesting that legislators and administration officials work for them, key interest groups are wary of saying things and taking positions which would receive a negative response from those public officials. The suggestion that the legislators and regulators dance to the tunes played by the special interests is simply not credible. (NO)

Massachusetts: Throughout the history of the Mass. system, legislators and Administration officials have had an active role. The chief exception to the trend was in 1981-82, when the Business Roundtable filled a policy vacuum during the years of Gov. Edward King and drove the process that created the Chapter 372 all-payer model. The deregulation process, though, provides the clearest evidence relating to the hypothesis.

In December, 1990, the Mass. Hospital Association surprised most observers by voting for a continuation and modification of rate regulation after the Chapter 23 sunset date of September 30, 1991. Later that month, a Special Commission voted by a wide margin to back a Maryland style regulatory model. Newly elected Governor William Weld and his chief health advisor, Charles Baker are credited by all observers with turning that wobbly consensus on its head, and starting the march toward deregulation. When the Administration tried to mollify critics by proposing a three year phase out of rate regulation, House Ways and Means Chairman Thomas Finneran changed the dynamic by producing a bill calling for immediate deregulation. His form is what reached the Governor's desk for signing.

The key interest groups, while endorsing a move to deregulation, were far more tentative and cautious than were the key governmental officials. Included in this characterization are the hospitals who initially favored a Maryland style alternative, business leaders who sought an elusive form of global hospital caps, insurers seeking a much longer transition, and labor leaders who were unable to articulate a clear position on the matter. The deregulation decision in Massachusetts was driven overwhelmingly by state policy makers, legislative and executive, and the key interest groups largely went along for the ride. (NO)

New Jersey: Administration officials, more than legislators, were in the lead in establishing and running the New Jersey rate setting system. The move to create DRGs was very much governmentally driven by the Department of Health and the core of specialists they hired, including Bruce Vladeck. Once again, the deregulation period provides the most useful portrait of public officials' involvement.

During his first two years in office, Gov. James Florio became increasingly disenchanted with the DRG rate system, as did his key health advisor, Brenda Bacon. On the day of Judge Wolin's ruling, Gov. Florio spoke first about the need to dismantle the system, before the affected interests weighed in. The new Republican majorities in the Assembly and Senate had wanted to dismantle the system for some time, and seized on the opportunity created through the Uncompensated Care Pool crisis. Rate setting did not have to go in 1992 -- it was a deliberate, policy driven decision.

The interests represented in the New Jersey Health Care Reform Coalition helped to develop the public consensus behind deregulation. But their key recommendation called for a three year phase out of the system, a proposal rejected out of hand by both the Governor and the legislative leadership. (NO)

New York: The names involved in establishing and maintaining NYPHRM and its predecessor statutes belie any notion of government officials as passive: Assembly Majority Leader James Tallon, Senator Tarky Lombardi, Governor Mario Cuomo, Health Commissioner David Axelrod, and others. These were individuals with sharply defined and commonly shared visions for the health system, visions that they worked aggressively to impose on an often reluctant system.

In the current process that will lead to deregulation, newly elected Governor Pataki helped to set the tone by establishing a deregulation mandate throughout state government, wherever possible. His Health Commissioner, Barbara DuBuono, has taken the lead in attempting to define how access provisions will be defined in the post-NYPHRM environment, an approach affirmed by the Governor in his March 20, 1996 call

for NYPHRM's complete deregulation.^{cccciv} The new Senate Health Committee Chairman, Kemp Hannon, proclaimed "no more NYPHRM's" early in the process in 1995. And his Assembly counterpart, Richard Gottfried, has made it clear that he will fight aggressively to preserve maximum access guarantees, despite whatever deals may be cut by the involved constellation of interest groups.

These directions are all taken in an environment where the hospital organizations are divided and at odds with each over the parameters of the coming debate. In the end, it will most likely be a debate about the amount of money put into the system to care for access obligations. Those decisions will be governmentally driven. (NO)

E5: Identifiable shifts in overt political support from affected interests to key legislative leaders should be identifiable.

This hypothesis will be discussed grouping all four subject states together, because the results are similar for all four. First, in no state did any of the 60 interviewees answer affirmatively that decisions by public officials about the fate of hospital rate setting were driven by campaign donations from affected interests or similar politically motivated concerns. Additionally, interviewees were unable to report any awareness of changes in patterns of political donations from key interest groups during the period leading up to the deregulation process. Also, interviewees (a politically savvy and well-connected set of individuals) were not at all consistent in their judgments concerning which groups and interests provided the most important levels of political support.

Second, in all four states, reports of political action committees filed at offices that regulate campaign finance matters were examined in the three year period before, during, and immediately after the deregulation decision. Political committee records examined included those of hospitals, insurers, HMOs, labor, and more. There was no evidence

^{cccciv} New York Times, March 21, 1996, pg 1.

that could be gleaned from these filings to suggest any overt shifts in the kind or amount of campaign donations from interest groups to key legislative decision makers.

Third, individual reports of several key legislators in each subject state were examined to observe any identifiable shifts in levels of support from key interest groups. Again, no pattern could be observed reflecting any shifts in support from political action committees or other sources that could be identified. A limitation to this third observation is mentioned below.

Finally, the summary of rate setting developments in each state outlined in chapter four suggests a clear rationale for the directions taken based upon both policy considerations and the input provided by key constituencies. The strikingly similar patterns observable in the deregulated states, together with the contradiction to that pattern observable in Maryland, undermine the notion that decisions by key policy makers about the future of rate setting were up for sale to the high bidders. No evidence could be found that would lend support to the hypothesis, and thus the conclusion for all four states, as well as the summary judgment is (*NO*).

However, the following three caveats must accompany this conclusion to hypothesis E5. First, there is no ability to track the occupation and organizational affiliations of individual campaign donors; thus, shifts in the levels of support from individual contributors associated with affected interests would not be detected by the examination means utilized. For example, individual contributors who give because of their ties to insurance, hospital or business interests cannot be identified simply by examining campaign finance documents. Second, campaign finance record reporting requirements vary from state to state, and the consistency in the materials examined was not uniform, making cross state observations risky and unreliable.

Third, and most important, an examination into campaign finance documents of this sort fails to capture the impact of changes in those occupying leadership positions. For example, in the year of New Jersey's deregulation, the Assembly elected a new,

Republican Speaker for the first time in many years. That individual was always opposed to the State's DRG system, but only in 1991 from the Speaker's vantage point. Thus, the change in the Speakership was a key factor leading to New Jersey's deregulation -- but not any particular change in the level of interest group support to that individual.

From this survey and analysis, we can conclude that interest groups played a critically important role in the development and disposition of rate setting in the subject states, even though the hypotheses of the theory of economic regulation are not supported. Next we will examine the role of ideas and the specific hypotheses of the punctuated equilibrium model.

Notes to Chapter V

- [1] Stigler, G., *The Theory of Economic Regulation*, in *Chicago Studies in Political Economy*, G. Stigler, Editor. 1988, University of Chicago Press: Chicago. p. 209-233.
- [2] Ibid.
- [3] Feldstein, P., *Health Care Economics*. Third Edition ed. 1988, New York: John Wiley & Sons, p. 305-9.
- [4] Becker, G., *Public Policies, Pressure Groups and Dead Weight Costs*, in *Chicago Studies in Political Economy*, G. Stigler, Editor. 1988, University of Chicago Press: Chicago. p. 85-105.
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CHAPTER VI

IDEAS AND THE FATE OF HOSPITAL RATE SETTING

"It wasn't partisan. There was no legislative/executive distinction. There was no inside/outside government distinction in our mindset of how the world of health care economics worked. Then, all of a sudden, people went: 'Oh, maybe it doesn't work that way. Maybe the emperor has no clothes.'" ^{xxxxv}

Ideas matter ... sometimes. When and how they matter is a central question of this chapter and indeed this study. There are times in political battle when the competition of interests prevails, and ideas are at best secondary, and often non-existent. But there are other times when it is ideas that are in competition, and when a more fundamental level of discourse concerning appropriate policy directions is held. At those times, affected interests often play only supporting roles, and must learn to accommodate to the new or prevailing policy ideas. A key observation of this study is that when prevailing policy ideas are generally accepted and largely unchallenged, interest group politics prevail. But when the central policy idea is up for grabs, and the competition for dominance is serious, then normal interest group rivalry stands to the side until the idea rivalry is settled.

This framework fits well with the rate setting case histories from our subject states. Rate setting systems were established during a period of time when the prevailing policy idea for how health providers should be paid -- cost-based retrospective reimbursement --

^{xxxxv} Interview with Gerry Billings, Exec. Dir., State Communities Aid Association, Albany, 6/30/95

was under attack as inflationary and inefficient. Prospective payment, a method to rearrange the incentives faced by medical providers, was proposed during the 1960s and 1970s as a replacement policy idea. The agent to enforce the new system at that time had to be government, because no other party held sufficient leverage over the provider community. Interests outside government -- including business, labor, and insurers -- accepted this necessary role for government largely without objection. During the succeeding decades of state-based prospective rate setting, when the reigning policy idea went largely unchallenged, battles over rate setting became battles among key interest groups over their roles and the rules of the system.

Gradually, a new idea came to challenge state-based prospective rate setting. It was not a return to cost-based reimbursement, or even the elimination of provider reimbursement regulation. The new idea, rather, was that the private sector -- using capitation and other advanced forms of prospective payment regulation -- had reached a developmental stage where it could do a better job than government in controlling and even reducing provider payments. Further, the new policy idea proposed that a payment system emphasizing competition among payers and providers would be more efficient than the prevailing system that emphasized uniformity and equity in payment structure. It is the resulting competition between the old and new policy ideas that most characterizes rate setting deregulation.

On the national level, a debate between competition and regulation proponents raged fiercely beginning in the late 1970s and into the early 1980s. While this debate focused on many areas of the economy, health care received a good share of the attention. Regulation advocates described health care as an example of market failure, with government intervention needed to control costs and to address growing access gaps. Competition advocates focused their attention instead on changes in the structure of the health economy needed to correct the market failure. Substantial research and policy writing on the topic was published during this period, with the alternatives between

mandatory hospital rate setting versus market competition a frequently cited example for both sides. [1] A key article by Goldsmith in 1984, "The Death of a Paradigm," pointedly noted the emerging shift in the balance of power between providers and purchasers in the health sector and the ramifications of the change: "The economic power of providers, nurtured for decades, has begun to shift from those who provide care to those who pay for it ... The health sector is a vital active enterprise in the midst of revolutionary change." [2] By the late 1980s, the national debate over state rate setting had largely subsided without an apparent winner. ^{ccxcvi}

While the results of the national debate were inconclusive, the health system changes noted by Goldsmith gradually began to develop significant momentum in various states. It took some years for the implications of Goldsmith's observations to become apparent in the rate setting states that deregulated, and the results were not uniform over time. Partially this time lag can be attributed to the differential rate of growth in managed care in the various states, as well as the normal variation in the rate of diffusion in policy ideas in regions and states.

Mitnick notes that the political and legislative processes involved in deregulation can be as burdensome and time consuming as those involved in initially establishing regulatory forms: "Deregulation ... is itself a policy that must reach an institutional agenda, be subject to decisions on that agenda, and experience implementation ... The characteristics of the policy formulation and implementation process for deregulation are therefore similar in many major respects to that of the process for regulation." [3] (pg431) But clearly, the changes that occurred in health policy in the subject states had their roots

^{ccxcvi} For example, the five year *Health Affairs* index, 1982-1986, contained a separate category entitled "State Rate Setting" with 17 references; the 1987-1991 index contained no such category, and only two state rate setting references, both of which were from the year 1987.

in ideas, literature, and discussion that has been in circulation for more than a decade before the Massachusetts deregulation.

This chapter's investigation into policy ideas and rate setting utilizes Baumgartner and Jones' punctuated equilibrium model of policy change as a rival to the theory of economic regulation in explaining the fate of mandatory rate setting in the subject states. In this chapter, we will briefly review the most important features of the punctuated equilibrium model, examine the policy ideas debate in each of the subject states, and finally examine the specific hypotheses of the model in light of the evidence collected. Table 6.1 below specifies the hypotheses for this model that were originally presented in chapter two.

Table 6.1: Punctuated Equilibrium Model Hypotheses

P1.	There should be an identifiable "policy idea" accompanying deregulation.
P2.	In Maryland, we should be able to observe the non-emergence of the new policy idea or clear indications of non-acceptance.
P3.	In deregulated states, we should observe altered institutional structures to account for the demise of the old idea and the ascension of the new one.
P4.	In Maryland, we should observe no similar institutional change.
P5.	In deregulated states, we should observe the emergence of new players who, by broadening the scope of conflict, undermined rate setting's policy monopoly.
P6.	In Maryland, we should observe no such no players, or clear indications as to their ineffectiveness.

We review the theoretical groundwork explored in chapter two because the insights of the punctuated equilibrium model appear more striking in light of the detailed discussions of rate setting developments described in chapters four and five. Essentially, the punctuated equilibrium model of policy change describes the emergence and recession of policy issues from the public agenda. During periods when issues emerge, new institutional structures are created that can remain in place for years and decades,

structuring the illusion of equilibrium, participation and consensus. Baumgartner and Jones refer to "policy monopolies" as the combination of public and private interests that manage the overall system. Once established, the policy monopoly goes through a period of equilibrium characterized by incremental change and the appearance of stability. Two elements most distinguish the policy monopoly: first, a definable institutional structure responsible for policy making; and second, a powerful supporting idea. "... (S) tability may be maintained over long periods of time by two major devices: the existing structure of political institutions and the definition of the issues processed by those institutions." [4]

While some analysts of the policy process have described incrementalism and a slow pace of change as its characteristic features [5], others such as Riker have observed that "(d)isequilibrium, or the potential that the status quo can be upset, is the characteristic feature of politics." [6] Any time that political actors, new or veteran, can enlarge the scope of conflict by bringing in new participants, adding fresh issues, or by creating fresh definitions of old issues, then the seemingly serene policy monopoly can be upended. Meier suggests that each policy subsystem is characterized by one of three states: first, domination by a single interest; second, competition among interests; and third, disintegration. Most systems at different times travel through all three stages, but static snapshots that are common in much policy analysis can easily miss the dynamic nature of this evolutionary process. [7]

Eventually, agenda access allowed to other groups can destroy existing policy monopolies and the institutional structures that they created, replacing them with a new policy monopoly as well as new or altered institutional structures. Central to Baumgartner and Jones' model is the suggestion that the generation of new ideas is what makes existing policy monopolies unstable in the long run. The destruction of policy monopolies is almost always associated with a change in intensities of interest, where people and groups that had once shown little or no interest become involved. "That reason is typically a new understanding of the nature of the policies involved ... Issue definition, then, is the driving

force in both stability and instability, primarily because issue definition has the potential for mobilizing the previously disinterested.” [4]

In the succeeding section, we will explore the dynamics of issue definition, agenda access, equilibrium, and policy monopolies in the subject states.

Policy Ideas in the Subject States

Maryland:

“The people want to keep the system as long as the philosophical underpinnings can be carried through and maintained in this era of HMOs and competition. The key is equity, that charges should bear a reasonable relationship to costs. Also fairness, to avoid cost shifting, so that everyone pays the same as every other person. This was a great departure from what was going on at the time ... The Commission has held fast to the basic concepts, but the methodology has changed significantly.”^{cxcvii}

Rather than a response to the demands of key interest groups, the original bills filed in the Maryland legislature in the 1967 to 1970 period were the response of concerned legislators to rising health and hospital costs. Those early bills were not sophisticated in their structures, but laid the groundwork for the policy debate that ensued in 1971 over legislation that established the HSCRC. Consistent with Baumgartner and Jones’ model, the Maryland rate regulation structure was established during a period of significant political upheaval. In 1971, newly elected Governor Marvin Mandel made the adoption of hospital rate regulation a centerpiece of this consumer protection agenda. By that time, a large number of legislators were filing bills to craft one type of rate regulation or another. While the Maryland Hospital Association supported (and wrote) the bill that became law, they did so under the direction of trustee board members who rejected their

^{cxcvii} Interview with Eugene Feinblatt, Attorney, former Chair, MD Commission on Health Care Finance, Baltimore, 6/21/95

CEO's prior opposition for several reasons. One of their key reasons was to establish a more predictable and prospective form of reimbursement. The political upheaval included a pitched battle between hospitals and Blue Cross, with legislators and administrative officials attempting to mediate the dispute.

There is no evidence from journalistic accounts, documents, or interviewees that any other competing policy ideas were part of the 1971 process. Rather, the choice was to continue with cost based retrospective reimbursement, with its inflationary incentives, or else to move to a regulated and more predictable prospective structure. There is evidence from all three sources that the adoption of this new "idea" was an essential part of the discussion and process in 1971.

Following adoption of the new system, we can clearly observe the development of an institutional structure to carry out the objectives of the new idea, as well as the formation of a narrow policy monopoly to channel feedback and to maintain and protect the structure. The structure was the Health Services Cost Review Commission, housed within the Department of Health and Mental Hygiene, but granted independent authority to promulgate its own rules and practices, within a framework of broad legislative discretion. The policy monopoly consisted of the following primary and secondary key players: primary were the hospital association, and the leadership and staff of the HSCRC; secondary were key Executive Branch officials such as the Commissioner of Health, the few senators and delegates with a sophisticated understanding of the system, the AFL-CIO, Blue Cross, and commercial carriers.

During the ensuing 25 years, the Maryland rate regulation has undergone substantial changes in its reimbursement methodology, as outlined in chapter four. The changes have been attempts to respond to negative feedback on the operation of the system as well as efforts to keep up with changes in the health sector environment. Without exception, these changes have been negotiated within the structure of the prevailing policy monopoly. (For example, there have been no statutes enacted since 1971

modifying the system in any significant way.) Even the activities involving the federal Medicare waiver legislation were restricted to the closed circle and the Maryland congressional delegation. Fitting with the punctuated equilibrium model, these changes have all been incremental and evolutionary in nature. Always a concern of regulators in evaluating proposed changes is the “fit” of the change with the principles laid out in the original enabling statute:

“We go back to the original goals of the Legislature: cost containment, equity or fair payment for the system, access and accountability. Those are always what we go back to in assessing any given project ... When you get people in the room and talk about principles, you get remarkable consensus on what are the public policy issues from the overall state standpoint.”
 ccccviii

Virtually every individual interviewed could identify their version of the “policy idea” associated with the Maryland rate setting system. The key themes mentioned most often included: equity, a mechanism to control the growth in costs, fairness in the treatment of poor people, and correction for “market failure.” Every interviewee for this study could also identify the replacement idea that would succeed rate setting in a deregulation scenario -- this was most commonly referred to as “the free market,” whether the interviewee supported or opposed this notion. While interview subjects are not uniform in their assessment of the prospects for structural changes in the future, all agree that the market is the alternative:

“We fought the major interest groups to get rate setting enacted. And some groups are itching to fight again to open it up to the free market. This is about ideas.” cccvix

Interview subjects in all four states were asked to assess whether debates over rate setting in their states were more about ideas or competition among interests. Generally,

cccviii Interview with Robert Murray, Exec. Dir., HSCRC, Baltimore, 6/21/95

cccvix Interview with Casper Taylor, Speaker, MD House of Delegates, Annapolis, 6/19/95

Maryland opinions followed a pattern exhibited among subjects in all four states -- government officials view rate setting as being fundamentally about policy ideas, and interest group spokespersons view it largely as being about interest group competition.

There is also agreement that the fate of Maryland's long program in setting hospital rates of payment is not a compelling issue on the public agenda in the state at this time:

"Rate setting is not a front burner issue in this state ... Overall it's a plus, but it's not the panacea that the HSCRC says that it is." ^{exd}

"Health policy is not debated on the policy level in Maryland. There are two important things missing. The first is serious substantive debate at the legislative level. And second is an appreciation for the value of the free market. The free market doesn't get much sway here." ^{exdi}

The description of rate setting as a secondary issue in Maryland politics fits well with the punctuated equilibrium suggestion that successful policy monopolies are able to keep broad discussions of structural change away from the primary policy agenda. Much to the frustration of those who would like to change the system, its defenders have been able to prevent an adverse issue redefinition and to respond on their own terms to changes in the health care market place.

The key modification to rate setting in recent years has been the HSCRC's experimentation with capitated payment plans under a rate regulation umbrella. This is an evolution that has never been attempted within any rate setting structure. It represents Maryland regulators' unique response to new ideas about efficient ways to pay for health care services. It also helps to disarm critics who would complain that the system is unable

^{exd} Interview with Gerard Anderson, Professor, Johns Hopkins School of Public Health, Baltimore, 6/22/95

^{exdi} Interview with Thomas Goddard, Dir. of Leg. & Reg. Affairs, NY Life Health Plus, Green Belt, MD, 6/23/95

to respond to changes in the market. Again, these changes are designed to conform to the basic principles of the regulatory system:

“The objectives for us are to still allow for hospitals to compete on the basis of efficiency -- but to hold them harmless for price differences other than those based on efficiency, i.e., for differences in uncompensated care and graduate medical education. We want to hold them harmless for differences in severity.”^{exdii}

While all Maryland parties, in and out of government, watch developments in other states, and create room for experimentation and change in their model, they do so affirming the basic ideas written into the original enabling statute that are now 25 years old:

“The all-payor hospital rate regulation system is the cornerstone of Maryland’s long-standing history of pioneering, innovative public policy relating to health care delivery that is tailored to the unique needs of the citizens of this state ... (T)his system serves as a national model that has successfully demonstrated that the cooperative establishment of appropriate incentives can yield enormous social benefits as well as control costs...”^{exdiii}

The punctuated equilibrium model recognizes that any policy monopoly is more unstable than it might otherwise appear; the potential splits among hospitals and the possible desertion of key insurance-affiliated allies could also undermine the system. Political change, from Democrat to Republican control, would also place the system at risk. But for now, the Maryland system remains the sole example of a continuing and thriving rate setting policy monopoly.

Massachusetts: The hospital rate setting program in Massachusetts was borne from a disruptive and intense fiscal crisis and recession, and the need for policy makers to

^{exdii} Interview with Robert Murray, Exec. Dir., HSCRC, Baltimore, 6/21/95

^{exdiii} Preamble to Health Care Reform Act of 1995

rein in skyrocketing Medicaid costs. A series of pitched and broad based battles that included legislators, Administration officials, hospitals, business, Blue Cross, and commercial payers over a six year period finally led to the establishment of the all-payer rate regulation policy monopoly under Chapter 372 in 1982.

The essential policy idea behind Massachusetts rate setting, according to interviewees, had several facets: to control Medicaid spending by controlling all hospital costs; to minimize cost shifting among payers; to provide an honest broker between providers and payers to guarantee an honest price; and more fundamentally, to respond to market failure in the health sector by creating a “public utility” form of regulation. As with Maryland’s genesis, in Massachusetts, we can observe dissatisfaction with the ability of retrospective methods to control spending, along with the “idea” that controlling charges to all payers was necessary to provide effective controls on the rate of growth in Medicaid spending.

The institutional structure that accompanied the new system was an expanded and strengthened Rate Setting Commission with three full time commissioners and a professional staff. As was true in Maryland, the structure was located inside the larger governmental health structure, but provided with independence from direct day to day pressures. Institutional separation from the Medicaid program also guaranteed some degree of institutional rivalry. Unlike the similar regulatory bodies in Maryland and New York, the Massachusetts overseer suffered from mediocre staff salary levels and a rapid and regular degree of turnover that left regulators consistently weakened relative to the better paid professional staff from the hospital community. Indeed, it was considered common for hospitals to hire some of the best staff away from the Mass. Rate Setting Commission.

The new rate setting policy monopoly consisted of state regulators, hospitals, Blue Cross, commercial payers, labor, HMOs, and business. In the early 1980s, this monopoly revolved around the activities of Nelson Gifford, chairman of the Health Care Task Force

for the Massachusetts Business Roundtable, and the CEO of a manufacturing company. The informal, closed door Health Care Coalition became the locus of discussion for any and all changes in the hospital regulatory environment between 1980 and 1985. HMOs and labor were added to the Coalition after its initial formation, and only after complaints about their exclusion were lodged. Consumer groups argued for admission and were left outside the door.

Between the years 1982 and 1987, disputes concerning the rate setting system were dealt with quietly and without major controversy. But the process leading up to Chapter 23, the Universal Health Care Law of 1988, was open and confrontational. While much public attention was focused on the access debates relative to the uninsured, hospitals sought to expand the scope of conflict around hospital rate setting rules by bringing more than 10,000 hospital workers to the Boston Common in September, 1987 for a rally to demand more money for their institutions. To be sure, the intricacies of hospital finance that are part and parcel of the rate setting dialogue went over the heads of the vast majority of citizens reading about the health care controversies at the State House. The essential regulatory design questions still were discussed and understood by only a small number of players, but the policy process in no way resembled the peaceful and quiet negotiating process in evidence during 25 years of Maryland rate setting.

In Massachusetts, the policy monopoly's days of peaceful and restrained "equilibrium" were short-lived. We can attribute this difference from Maryland to a number of factors: first, the short-lived nature of each enabling statute, lasting only between two and four years; second, the lack of leeway provided to Rate Setting professionals, leaving all major policy questions up to the Legislature; and third, the large number of major hospitals that competed for financial and political leadership.

Following enactment of Chapter 23, hyper-inflation developed in Massachusetts hospital costs that further eroded much of the remaining support for continued rate regulation. A severe fiscal crisis gripped the Commonwealth in 1989, leading to a severe

budget shortfall exacerbated by double digit increases for the Medicaid program. A Special Commission in 1990 was unable to agree on the precise outlines of a regulatory system to replace Chapter 23 after the law's September, 1991 sunset. An accompanying crisis affecting the financial solvency of Mass. Blue Cross created an additional rationale for major policy changes.

While the controversy that accompanied rate setting deregulation was not intense, there were efforts by consumers, labor officials, and academics to prevent or to modify the move to abandon rate regulation. The consumer organization, Health Care for All, hospital worker unions, and health policy academics from Harvard, Brandeis, and Boston University all worked in various ways to challenge the growing consensus in favor of rate setting deregulation. Health Care for All organized press conferences, events, and other grass roots initiatives to win support for their single payer alternative plan. The labor groups, chiefly Service Employees International Union Local 285, produced their own report about the increasing corporatization of community hospitals and the implications for community care.

Academics played a more prominent role in the Massachusetts deregulation process than can be observed in any phase of rate setting regulation or deregulation in the subject states. Researchers from the Harvard School of Public Health and the Gordon Public Policy Center worked with House Health Care Chair Carmen Buell during the summer of 1991 to craft a hospital global budget cap, described as follows:

"H.5900 (Governor Weld's bill) is designed to lower aggregate hospital costs through increased competition. The proposed fail-safe mechanism is triggered *only* if aggregate hospital costs *increase substantially* under H.5900 ... Supporters of the competitive approach should in fact enthusiastically support such a fail-safe mechanism, exactly because it

effectively removes one of the serious concerns which might otherwise be raised against H.5900.”^{cxdiv}

The proposals made by the Harvard and Brandeis academics, incorporated into the Health Care Committee’s version, were dropped at the next stage in the House Ways and Means Committee, and never reappeared.

At Boston University, an “Access and Affordability Monitoring Project” affiliated with the School of Public Health had been producing reports on the Massachusetts health care market since the fall of 1988. In the summer and fall of 1991, they contributed a series of reports all of which sought to undermine the direction and support for deregulation. Some titles included: “Paying for Our Mistakes” (July 2, 1991); “A Reckless Miscalculation” (September 16, 1991); “No Scorpions Needed: Building Fair, Simple and Affordable Hospital Payments in Massachusetts” (October 1, 1991); “California’s Catastrophic Competition” (October 28, 1991); and “Manipulating the Minnesota Marketplace” (October 28, 1991).

The AAMP’s most controversial contribution to the debate was a report also issued on October 28, 1991 titled “Which Hospitals Are Vulnerable? Characteristics that Might Endanger Massachusetts Hospitals Under a Competitive Payment Plan”. Noting that “(s)everal experts have estimated that 10-20 additional hospitals will close within three years if the fully competitive method of paying hospitals now making its way through the legislature were to pass,” the Report ranked the State’s 91 acute hospitals according to seven financial characteristics. [8] While the activities of consumers, labor groups, and academics generated some media attention, and responses from pro-deregulation supporters, there is little evidence that their pro-regulatory activities made a significant mark in the process.

^{cxdiv} Draft memo to Rep. Carmen Buell from Martin Levin, Gordon Public Policy Center, Brandeis University, August 26, 1991

On the other side of the deregulation debate, interview subjects all agreed that a change in the prevailing policy idea was at the root of the deregulation decision, from start to finish. The Administration's point person, Charles Baker, saw dissatisfaction with the prior system as a primary cause for deregulation:

"There was a willingness on the part of a lot of people to try something new, which is not always there ... A big reason why (deregulation) happened was just because there were a lot of things that many people couldn't stand about Chapter 23. A lot of people were punished for doing the right things. There were a lot of weird incentives for people not to do the right thing. Rate setting lost the capacity to represent a broader public purpose. What people want more than anything out of these processes is a level playing field."^{cxlv}

There is evidence that the Administration was concerned about the broader policy ideas and implications throughout the process. A September 2, 1991 file memo by Baker discusses "Johns Hopkins Professor Gerry Andersen's Presentation on Maryland and Minnesota Hospital Systems":

"In 1971, Maryland and Minnesota both had per capita hospital costs of about \$140. This was about 10 percent above the national average. In 1989, Minnesota's per capita hospital costs had risen to \$818, while Maryland's had risen to \$862. These numbers, in both cases, were below the national average. Conclusion: competition or regulation both work - as long as one is consistent - although they accomplish different things."^{cxlvi}

At the other end of the process, the House Chairman of Ways and Means who put out the bill that led to a quick deregulation talks about his own developmental process in moving toward an end to rate regulation:

"I thought the deregulated market would be more coherent than the regulated market which was criticized for being inequitable, not fully factual, sometimes political ... As I recall, we caught the industry by surprise. This was a battle of ideas. This one I personalize. I struggled

^{cxlv} Interview with Charles Baker, Undersecretary for Health and Human Services, Boston, 12/27/94

^{cxlvi} Memo to files, from Charles Baker, September 2, 1991

with it inside. I was not aware of anyone's interest on it outside. I spent the greatest amount of time on this one talking with Joe Trainor (Budget Director), not far behind that talking to you (author) and talking to Carmen. Testing myself, asking your thoughts and opinions. It was all ideas.”^{cxvii}

Other participants and observers in the deregulation process had similar impressions that -- at least during this debate -- ideas counted:

“A lot of education went on with the (House) members. It was a debate about the shift in ideas, and the sense that it was time to try something new.”^{cxviii}

“I remember the hearing before the Health Care Committee that summer when Baker spoke with such assurance, and the hospitals were supportive as well as the representatives from the business community. It was the first public manifestation that this was an idea that had come of age. It was clear that the idea had arrived.”^{cxlix}

“It's always about interest groups from day one. But it was also an idea thing. The Weld people brought a philosophy and a perspective about markets that was different than the Dukakis people and Democrats in general. To them, market failure wasn't one word.”^{cl}

We can thus observe that a clash of ideas accompanied the Massachusetts deregulation experience -- whether or not that debate had any major impact on the final deregulation statute. The final element in this part of the story is the punctuated equilibrium model's prediction of an altered institutional structure in states undergoing deregulation. In Massachusetts, this altered structure is apparent on several levels. First, the Rate Setting Commission lost its authority to establish prospective hospital charges.

^{cxvii} Interview with Thomas Finneran, Chair, House Committee on Ways and Means, Boston, 1/21/95

^{cxviii} Interview with Carmen Buell, House Chair, Joint Committee on Health Care, Boston, 12/28/94

^{cxlix} Interview with Elizabeth Rothberg, Issues Director, Life Insurance Association of Mass., Boston, 12/29/94

^{cl} Interview with Robert Hughes, Exec. Dir., Mass. Assn. of HMOs, Boston, 12/15/94

The agency has been downgraded to role of an information gatherer. At the same time, the Medicaid Program saw its status increased from a agency within the Department of Public Welfare to a special division within the Secretariat of Health and Human Services; the Medicaid Program was authorized to negotiate its own rates of payment without Rate Setting oversight or approval. The Department of Mental Health was granted authority for the first time to conduct its own rate negotiations with hospitals. Finally, a new oversight agency -- called the Hospital Payments Advisory Commission, or HOSPAC -- was created in 1992 to monitor developments in the new competitive marketplace and to report on developing trends to the Legislature. That new entity was defunded and terminated in mid-1995.

New Jersey: The creation of the New Jersey system of hospital rate regulation was spread out over the longest period of time, with initial forays directed at Blue Cross more than the hospital sector. As hospital costs began to escalate at a faster rate, the Blue Cross mechanism was seen as a convenient point of entry to broader controls. Mandatory hospital budget controls were adopted in 1971 that were left in the hands of an organization affiliated with the New Jersey Hospital Association. A 1974 book that exposed the ineptness of that model led to the enactment of Department of Health controls in 1975, and the establishment of the SHARE program in 1976.

There is strong evidence that ideas played a prominent role in the creation of the DRG, all-payer system between 1978 and 1982 -- perhaps even too much so. The newly appointed Commissioner of Health, Joanne Finley, in 1975 used her authority to attract \$3 million in federal funding to enable the state to launch the nation's first experiment with case based prospective payment. Analysts who have studied the New Jersey system have noted the prominence of ideas in that model: "The prominence that DRGs have gained in current health policy is partially explained by the seductiveness that economic incentives hold for policy analysts. Economic logic appeals to common sense and its prescriptions

appear to be self-executing: change the financial rewards and behavior changes ... An alternative perspective, that of organizational theory, describes hospitals as complex, and dominated with multiple objectives and well established routines. Such an institution can be expected to resist externally imposed pressure to change in directions that threaten preferred values and relationships.” [9]

There is also evidence that dissatisfaction with the SHARE program’s structure played an important role in the DRG experiment: “Prospective payment on a per diem basis is often criticized for its encouragement of longer length of stay, because days of care at the end of a stay are often less intensive and costly than earlier days. Other alleged problems with the SHARE system were that it ignored hospital case mix differences, did not effectively link clinical and financial decisions, encouraged hospitals to shift costs to unregulated payers, and failed to fully compensated New Jersey hospitals for care rendered to indigent patients.” [10]

Rather than turning the DRG design challenge over to the affected interests, New Jersey policy makers recruited a skilled team of health policy specialists led by current HCFA Administrator Bruce Vladeck, who served as Assistant Commissioner between 1979 and 1982. In the recruitment story rests an important lesson for policy makers: “We conclude that it is less difficult to bring together a talented group for designing a new program than it is to hold one together for the arduous task of program implementation and refinement ... By 1982, the Department of Health had suffered almost 100 percent turnover of DRG project personnel ... If government is to be effective, the limits of its administrative capacity must be recognized.” [11]

One reason why so many of the original framers of the DRG system left was the election in 1981 of Republican Thomas Kean to the Governor’s Office. Many suspected that the new Governor would thwart DRG implementation before the final phase-in was completed. He didn’t, and in fact played the key role in convincing a very reluctant Reagan Administration and HCFA bureaucracy to renew the State’s Medicare Waiver.

[12] He did so for two key reasons. First, the NJHA decided to support the state prospective payment model as an alternative to the looming federal PPS structure. But also, no alternative method to control hospital cost inflation was in sight of the Governor. Governor Kean bought into the idea of prospective payment regulation, much in the same way that the free market Reagan Administration bought into national prospective rate setting for Medicare -- because of the lack of viable alternatives.

A new institutional structure was created through a Rate Setting Commission to implement the new prospective payment program. The policy monopoly included state regulators and hospital officials first and foremost. While other groups such as business, labor, Blue Cross, commercial payers and others had seats at the table, as described in chapters four and five, all of them felt outside of the inner circle of decision making. While throughout the state, hospital consumers were complaining to legislators about the size of their hospital liabilities in relation to the hospital's charges, at the meetings of the Rate Setting Commission, it was apparent that the system was an insider's game:

"I remember sitting at one hearing. The hospitals would say: 'These are our shortfalls.' The payers would say: 'No, we disagree.' The body would almost always arbitrate somewhere in the middle."^{cli}

"Rate setting was not working very well. It was more like a rubber stamp of whatever the hospitals wanted. I don't recall any hospitals having a difficult time getting their rates increased."^{clii}

Unlike the deregulation process in Massachusetts and New York, the abandonment of rate setting here involved less the understanding that a system based upon negotiated rates would be more effective and more the sense that the New Jersey regulatory structure had simply failed:

^{cli} Interview with Dennis Marco, Blue Cross & Blue Shield of NJ, Newark, 4/20/95

^{clii} Interview with George Laufenberg, Administrator, NJ Carpenter's Fund; former Rate Setting Commission member, Edison, NJ 4/19/95

"The benefits of rate setting were that it was not the previous system -- fee for service running up bills without any constraints. It worked well at first and still would be regarded as an improvement on the prior situation. But it was starting to yield less and less."^{cliii}

Governor Florio is regarded by most New Jersey interviewees as the individual who most brought ideas to the deregulation process. Prior to Judge Wolin's ruling in May, 1992 that threw out the state's method of financing uncompensated care, Governor Florio had organized commissions and other groups seeking changes both in uncompensated care and in rate setting. He had been examining health system reform efforts in other states, and had put forward ideas to deal with a growing number of the state's citizens without health insurance coverage. While much attention during the summer and fall was focused on finding a replacement source of financing for the Uncompensated Care Trust Fund, Florio himself placed considerable weight behind companion bills to reform the state's small group and non-group health insurance markets. He had already decided that the rate setting structure should be eliminated, but used his agreement with the Legislature on deregulation to leverage legislative support for his insurance reform initiatives:

"Governor Florio is one of the people who most consistently had some vision of where he wanted to go, and found ways to drive the processes. Florio clearly had vision."^{cliv}

But perhaps because managed care penetration in New Jersey was far less than that of other rate setting states, the precise replacement idea was far less clear and consistently held than in the other two deregulated states. New Jersey interviewees varied in their assessment from "no policy idea -- I couldn't come up with one" to "we were prepared to let the market work" to "the regulatory system didn't work". Though some

^{cliii} Interview with James Florio, Governor, New Brunswick, NJ, 4/17/95

^{cliv} Interview with Maureen Lopes, Senior VP for Health Affairs, NJ Business & Industry Council, Trenton, 4/17/95

members of the New Jersey Health Care Reform Coalition clearly saw a need to bring more market forces into the hospital regulatory environment, even their position was somewhat muddled, advocating for a three year transition to deregulation. Their preamble and problem statement highlights the ambiguity:

“...to develop and propose a new, long term approach to the structure and financing of health care in New Jersey. Our goals have been to replace chaos with order, provide universal access to ‘high’ quality care at an affordable and equitable cost, and to reexamine (and possibly reorganize) the complex and interrelated web of health care issues which together comprise the health care system ...” ^{clv}

The Coalition and its constituent organizations’ agendas were foggy. The Legislature primarily wanted to get rid of rate setting and to find a politically acceptable way to finance uncompensated care. The driving vision, and the one realized, was Governor Florio’s -- to replace a dysfunctional regulatory structure that failed in its efforts to control hospital spending with a new structure that focused on providing affordable health insurance choices to individuals and small business. The switch in governmental focus -- from institutions to individuals -- and also from institutional subsidies to individual insurance coverage, was critical in understanding Florio’s vision.

In the wake of deregulation, key structural changes were made in state government. The Rate Setting Commission -- and the State’s role in establishing hospital charges -- was eliminated. New state agencies were established to meet the new state agenda. The key one was called the New Jersey Essential Health Services Commission. Its principal duties were: first to oversee payments to hospitals for uncompensated care; second, to develop a subsidized health benefits program for low-income and uninsured New Jerseyans who are working or temporarily unemployed. Unlike the prior uncompensated care arrangements, payments to hospitals for bad debts were not longer

^{clv} New Jersey Health Care Reform Coalition, June 1992

permitted, and only payments for income eligible uninsured persons were allowed. In addition, advisory boards were established to oversee both the small group and non-group insurance market reforms.

Since deregulation, New Jersey's agenda of reforms has experienced a series of ups and downs and modifications. But the aftermath should not at all obscure the achievement made in 1992 in turning a Judge's ruling on uncompensated care funding into a mandate for broader, systemic health reform:

"This was one time where the policy makers made a bold move and instituted a good reform that went beyond what any of the groups wanted. It was about an idea. There was a common thread through all three of the bills -- the system is broken."^{clvi}

New York: It is in New York that the influence of ideas on the development and deregulation of rate setting is most evident. While cost pressures in the Medicaid program were prominent in leading to its creation in 1969, the state's strong political culture favoring regulatory solutions to a host of social and economic problems made the establishment of mandatory prospective payment a natural fit -- even during the years of Republican political domination by Nelson Rockefeller.

The structure of the policy monopoly was contained within the State Department of Health, and in particular in the Office of Health Systems Management, but effective control was given to the Commissioner, and not to an independent commission as occurred in Massachusetts, Maryland, and New Jersey. New York policy makers did not fear the concentration of regulatory authority in one person's hand, and a small succession of commissioners, especially Dr. David Axelrod, used the authority comfortably to bend hospital finances to the will of the state.

^{clvi} Interview with Dennis Marco, Vice President, NJ Blue Cross and Blue Shield, Newark, 4/20/95

In his discussion of regulatory regimes and the politics of hospital reimbursement, Hackey uses the New York NYPHRM model as an illustration of an imposed regime “characterized by the relative strength of the state’s regulatory capabilities in relation to the regulated industry; rules, regulations, and prices are dictated by state officials, often amidst cries of protest.” Unlike rate setting programs in Massachusetts and New Jersey, the New York system was able to retain a long-term group of experienced and sophisticated program managers and regulators. “From top to bottom, the behavior of public officials in New York’s Office of Health Systems Management is guided by a coherent and powerful set of role orientations and ideological beliefs that have solidified over time.” [13]

During the 12 years of legislatively created NYPHRMs I-V, all was not peaceful within the policy monopoly that included hospitals, Blue Cross, commercial payers, business, labor, and -- most prominently -- state government regulators and legislators. The regular involvement of legislators meant that parties had access to other means than the bureaucrats in seeking changes to the system:

“I’ve also noticed that a lot of the newspaper stories about hospital financial distress will correlate closely in timing with the closeness of the NYPHRM legislative review.”^{clvii}

All New York interviewees were able to articulate a clear sense of the supporting policy idea that sustained rate setting in the state since 1969. The core of the idea included: public or social control of health care resources, control of hospital costs and financial security of vulnerable hospitals, payer equity, and preservation of access -- all accomplished by a strong centralized bureaucracy.

The critical factors leading to the deregulation process in New York were outlined and explored in chapter four, including the recent and rapid growth in managed care

^{clvii} Interview with John Rodat, Consultant, Albany, 6/30/95

penetration and the accompanying practice of discounting between hospitals and HMOs, the political change with the election of George Pataki as governor, the growing disillusionment with rate setting's performance, and the changing interest group landscape. But also of significance was the role played by policy ideas in bringing individuals and interests to a different understanding about NYPHRM.

Key in this process was a report published in March, 1995 for the State Communities Aid Association and the Life Insurance Council of New York by a former Department of Health and legislative staff person, John Rodat. The report, mentioned previously, was titled: *"NYPHRM's Paradox: How New York's Attempts to Stabilize Hospital Finances Lead to More Uninsured, Increased Benefit Restrictions, Reduced Hospital Utilization, & Weakened Hospitals"*. The Report reached the following base conclusions: 1) New Yorkers pay more for hospital care than residents of all but one other state (Massachusetts), while hospitals are financially weak; 2) many New Yorkers are losing private health insurance primarily because of rapid premium growth; 3) NYPHRM's statutory price escalator -- the 'trend factor' -- drives up hospital payments leading 'directly' to premium increases and tax increases for Medicaid; 4) payers move aggressively into managed care and negotiated rates as well as drop coverage in order to survive; 5) Payers' actions lead to reduced hospital utilization, reduced hospital revenues, and increased hospital instability; 6) "New York's regulatory system was designed during the late 1960s for the health care system of that day. *None of the key factors that characterized the health care system for which the regulatory system was designed is still true today.*" The principal conclusion made by Rodat was that New York rate regulation should be abandoned. [14]

While questions and issues can be raised concerning Rodat's methodology and conclusions, there is little doubt that his report had a significant impact on the thinking of some key New York policy makers:

"Eliot Shaw from the Business Council described an interesting experience: the Business Council had always advocated more regulation. But a couple of his members kept coming back and saying, 'Now explain to me again *why* we're supporting regulation.' When John's article came out, one of the members brought it to him and said, '*This* is what I have been trying to say.'" ^{clviii}

"We retained John Rodat. We defer to him now to be the institutional knowledge on the system. He has made the case that NYPHRM over the years has changed. What happened has evolved over time, and things are not the same now as when they started. It's now hurting, artificially raising the rates, propping up an overbedded system that causes insurers to raise rates, and causes more people to be uninsured. It becomes an endless cycle." ^{clix}

Other interviewees agreed that the release of the Rodat report was a turning point in discussions about NYPHRM, and that after publication, parties began to discuss more openly the abandonment of rate regulation. The substitute policy idea is similar to that in evidence in Massachusetts and, to a lesser extent, in New Jersey: the marketplace will be a better force for cost containment, and the control of health resources by capital instead of by social forces. There is some degree of irony and even regret on the part of some interviewees who have long been associated with different versions of NYPHRM:

"There has never been a concerted move to eliminate it (NYPHRM). The alternative was never seriously presented on the table ... There has not up until now emerged a powerful ideologically driven Republican philosophy of deregulation in New York -- up until now ... The Republican Party in New York is still descended from the legacy of Nelson Rockefeller, and was powerfully involved in creating the system." ^{clx}

"The system originally was thought of as a way to keep a ceiling on costs, which is basically why the business community originally supported it. In recent years, it

^{clviii} Interview with Gerry Billings, Exec. Dir., State Communities Aid Assn., Albany, 6/30/95

^{clix} Interview with Diane Stuto, Vice President, Life Insurance Council of NY, Albany, 7/21/95

^{clx} Interview with James Tallon, former Assembly Majority Leader, now United Hospital Fund, Portland, OR, 8/6/95

has in many ways served to keep a floor on costs and to keep up revenues to hospitals which is partly why I have supported it, and why the business community has done an about face on it.”^{ebi}

“How simple it is to be such a believer in marketplace dynamics! It takes the obligation of ever having to answer a difficult question away. Just trust the marketplace. It will take care of it.”^{ebii}

While the actual form of deregulation has not been legislated as of the writing of this report, the structural shifts are beginning to take form. First, nearly all of the key rate setting regulators who populated the Department of Health for more than a decade have left state government. The continuity in professional managers, a hallmark of the NYPHRM system, is a thing of the past. While the precise structural changes have not been settled, the conceptual foundation for the new structure is now under discussion. The recent DoH NYPHRM Task Force outlines the basic thrust: “With market forces exerting economic pressure on the health care system, the Task Force no longer considered it necessary for the state to regulate the reimbursement of hospitals. Instead of a large regulatory role for the state, the Task Force envisions a more targeted state role in quality assurance and in areas that the market is unlikely to address.” [15]

While the philosophy of regulation appears to be changing, some aspects of the New York political culture have not:

“There is still a powerful set of voices not to walk away from graduate medical education and uncompensated care because it is morally and ethically important. This is still a government that sees its responsibility to make the decisions ... This discussion is policy driven. Those discussing it

^{ebi} Interview with Richard Gottfried, Chair, Assembly Health Committee, New York City, 7/20/95

^{ebii} Dan Sisto, President of HANYS, quoted in Council on Health Care Financing proceedings, June, 1995

from the policy view understand that this a collective bargaining issue among a multitude of interests.”^{elxiii}

Examination of Punctuated Equilibrium Model Hypotheses

Presented below is a table summarizing findings from each state (and overall) for each of the hypotheses specified in the punctuated equilibrium model of policy change:

Table 6.2: Punctuated Equilibrium Model Hypotheses and Results

	MD	MA	NJ	NY	Overall
P1. An identifiable “policy idea” should accompany deregulation.	-	YES	YES	YES	YES
P2. In Maryland, we should not observe the emergence of the new policy idea, or else have clear indications of non-acceptance.	YES	-	-	-	YES
P3. In deregulated states, we should observe altered institutional structures to account for the demise of the old idea and the ascension of the new one.	-	YES	YES	MIX ED	YES
P4. In Maryland, we should observe no similar institutional change.	YES	-	-	-	YES
P5. In deregulated states, we should observe the emergence of new players who, by broadening the scope of conflict, undermined the rate setting policy monopoly.	-	YES	YES	YES	YES
P6. In Maryland, we should observe either no such new players, or clear indications as to their ineffectiveness.	YES	-	-	-	YES

Evidence explaining the conclusions for each hypothesis and for each state will be presented in turn.

P1. An identifiable “policy idea” should accompany deregulation.

Massachusetts: Virtually every interviewee could identify a replacement idea to substitute for the policy idea associated with prospective rate setting, whether the

^{elxiii} Interview with James Tallon, former Assembly Majority Leader, now United Hospital Fund, Portland OR, 8/6/95

individual agreed with that idea or not. The replacement idea had the following two key characteristics:

First, while the (then) current rate setting system had once been somewhat effective in controlling the growth of hospital costs, it had failed to maintain the ability to control costs over the longer term; because of that change, central economic planning as the vehicle for health sector cost control had fallen out of favor.

Second, market forces had reached the point where they could be more efficient not only in restraining hospital and health sector costs, but also in doing something unthinkable under rate setting, namely, *reducing* the cost of those services. The mechanism for implementing this change was managed care and HMOs using their ability to negotiate rates of payment with hospitals. The best way for payers to reward efficient hospitals and to punish inefficient ones was to stop paying an arbitrary definition of "costs" and instead to pay prices based on the prevailing market.

In addition to comments by interviewees, there is substantial evidence from the legislative process that -- at several levels -- a serious debate about policy ideas ensued between those arguing for a continued rate regulation and those arguing for a system based on market based contracting. On the pro-regulation side were the consumer group, Health Care for All, labor unions, and supportive academics. On the market competition side were most prominently key legislators and Administration officials, Blue Cross, and the HMOs; the hospitals and business, while supportive of deregulation, confused their position by taking a number of contrary stances. The evidence for this debate is discussed in chapters four, five and six, and includes journalistic accounts, reports, and private notes.

The fact that the pro-regulation side was overwhelmed in votes and support by the pro-competition adherents does not at all diminish the assertion that competing policy ideas were a factor in the debate, and that the existence of a clear replacement idea was an essential element of the deregulation process. (YES)

New Jersey: The replacement policy idea underlying deregulation was less clear and consistent among the New Jersey interviewees than was the case in Massachusetts. Much more prominent in interviewees minds was the regulatory failure apparent in the workings of the DRG system in its final years. This difference can be attributed to the much smaller rate of HMO penetration evident in New Jersey in the years leading up to deregulation.

Nonetheless, there was also a growing sense that the market was a mechanism that deserved a try and more respect in the New Jersey health care environment:

“We were prepared to let the market work.” ^{clxiv}

“The market will work better and bring down prices.” ^{clxv}

“The market does better at controlling costs and rewarding efficiency.” ^{clxvi}

“Hospitals had grown fat, lazy, inefficient, out of control, -- you can’t close them -- let the chips fall where they may.” ^{clxvii}

While not widely shared, an additional replacement idea was put forward both in the interview for this study and in the legislative process by then-Governor James Florio, namely that the focus of government had to shift away from propping up institutions and toward ensuring adequate insurance coverage for individuals. He included this dynamic within his own description of his replacement idea, labeled “structured competition.”

^{clxiv} Interview with Dana Benbow, Vice President, Prudential Insurance Company, Iselin, NJ, 4/19/95

^{clxv} Interview with William Codey, former Senate Health Chairman, West Orange, NJ, 4/19/95

^{clxvi} Interview with Maureen Lopes, Senior VP for Health Affairs, NJ Bus. & Ind. Assn., Trenton, 4/17/95

^{clxvii} Interview with Thomas Terrill, Executive VP, University Health Systems, Princeton, NJ, 4/17/95

While his ideas were not broadly shared among interviewees, he was successful in seeing his proposed policies passed and implemented.

There is evidence from interviews as well as from records and news accounts related to the New Jersey Health Care Reform Coalition that policy ideas, new and old, were an important part of their process. Though they stood alone among the key interests, the urban and academic teaching hospitals waged a serious, though unsuccessful campaign to preserve the rate setting structure. Competing full page newspaper advertisements several days before the final legislative votes put the alternative ideas before the broad public. The first, from the Urban Hospital Coalition, stated:

"We can't say no to our patients. We shouldn't have to ... Urban hospitals need redistribution of the dollars in this bill to our hospitals to achieve the level of funding necessary to continue care for the indigent."^{chxviii}

On the other side, an advertisement signed by the New Jersey Business and Industry Association, the New Jersey Hospital Association, the New Jersey HMO Association, and the Medical Society of New Jersey, headlined: "End the Gridlock! Enact True Health Care Reform," stated:

"...precedent setting reform legislation hammered out by the Democratic Administration and the Republican legislative leadership ... would eliminate the inefficient DRG system of billing patients at average charges."^{chxix}

Clearly, the debate over replacement funding for the Uncompensated Care Trust Fund dominated legislative concerns and public attention during the review process. However, interviews, journalistic accounts, and other source documents substantiate the claim that a replacement policy idea to the DRG system was present and accepted during the course of legislative review. (YES)

^{chxviii} Newark Star Ledger, November 29, 1992

^{chxix} Newark Star Ledger, November 30, 1992

New York: Though deregulation has yet to occur as a legislative fact, it has become well established now as a replacement policy idea for 25 years of hospital rate setting regulation that reached its zenith during the five versions of NYPHRM. Whether complimentary or pejorative, all interviewees were able to characterize the replacement idea:

“Deep discounts -- negotiating on the basis of cost and quality.” ^{clxxx}

“The free market -- and chaos.” ^{clxxxi}

“The marketplace will be a better force for cost containment.” ^{clxxxii}

“Control by capital of health care resources -- instead of social control.” ^{clxxxiii}

As was true in Massachusetts, the rapid growth in managed care and HMO penetration has had a profound impact on the attitude of New Yorkers toward rate setting and government sector regulation. The principal evidence that ideas are a part of the New York debate is John Rodat’s report for the Life Insurance Council and the State Communities Aid Association which, as described in this chapter, precipitated a sea change in the positions of several key groups including the two sponsors and the Business Council of New York State, all former rate setting supporters.

Central to the punctuated equilibrium model and to this study’s conclusions is the assertion that ideas take front and center stage during the periods of instability and

^{clxxx} Interview with Ed Reinfurt, Vice President, Business Council of NY State, Albany, 6/30/95

^{clxxxi} Interview with Debbie Bell, Coordinator of Policy Dev., DC37, AFSCME, New York City, 7/20/95

^{clxxxii} Interview with Harold Iselin, Counsel, NY HMO Conference, Albany, 6/29/95

^{clxxxiii} Interview with Richard Gottfried, Chair, Assembly Health Committee, New York City, 7/20/95

systemic disruption, while interests move to the fore during the equilibrium phase. An offhand comment from one key participant affirms this insight:

“It hasn’t been about ideas in the past. Rate setting debates in New York State always have been about raw political negotiations with the hospitals always winning out. But thanks to John (Rodat) and others raising questions, it may be starting. We haven’t talked about ideas since we formulated the original NYPHRM... What we were trying to accomplish was to pull the conceptual underpinnings out of NYPHRM.”^{elxiv}

The actual legislative debate on NYPHRM’s future has not yet occurred as of the writing of this study. As occurred in New Jersey, the harshest debate most likely will concern the source and distribution of replacement financing for uncompensated care and other uses unique to the New York hospital regulatory environment. At this time, it is unclear whether anyone will step forward to promote a continued structure for rate regulation. If that does not happen, it suggests more that the replacement idea was long overdue rather than the non-existence of the new policy idea. (YES)

Summary: In all three subject states that have deregulated (or are about to do so), a clear replacement policy idea can be articulated and identified. In addition, we can identify clear indications that the ideas were accepted by key players in each state. (YES)

P2: In Maryland, we should not observe the emergence of the new policy idea, or else have clear indications of non-acceptance.

Health policy leaders in Maryland are aware of the evolution in health policy in other states, including states that deregulated their rate setting systems. The most commonly used description of the replacement policy idea came down to two words: “free market.” The second most commonly used term was “marketplace competition.” Clearly, the ideas that have been incorporated in the other states have also penetrated here, thus leading to a rejection of the first part of the hypothesis.

^{elxiv} Interview with Gerry Billings, Exec. Dir., State Communities Aid Association, Albany, 6/30/95

The second alternative is clear indications of non-acceptance. In this case, we can observe among interviewees clear signs of non-acceptance -- particularly among government officials -- or else reluctance to take any steps to promote the alternative policy idea. From some of those rejecting the free market were these comments:

“There’s no important political voice that wants deregulation to happen.”
clxxxv

“If it ain’t broke, don’t fix it.” clxxvi

“I have grave reservations that the delivery of health care lends itself to the free market.” clxxxvii

“If you have deregulation, then it’s like road kill. Everyone’s in here plucking this piece or that.” clxxxviii

Unlike the other three subject states, there is not a clear record of legislative policy debate that can help to define the nature of a clash in policy ideas. The only recent legislative activity, leading to the creation of a special review panel, included preamble language clearly expressing strong and continuing support for continued rate setting. There have been no major newspaper articles that have brought discussions on the future of rate setting to the fore. Almost all of the discussion is beneath the surface, and has certainly not affected the public consciousness in any meaningful way:

“Rate setting is not a front burner issue in this state.” clxxxix

clxxxv Interview with Eugene Feinblatt, Attorney, former Chairman, MD Comm. on Health Care Financing, Baltimore, 6/21/95

clxxxvi Interview with Sen. Paula Hollinger, Senate Chair, Joint Common on Health Care Delivery & Finance, Annapolis, 6/20/95

clxxxvii Interview with Casper Taylor, Speaker, MD House of Delegates, Annapolis, 6/19/95

clxxxviii Interview with Dr. Martin Wasserman, Commissioner, MD Dept. of Health & Mental Hygiene, Baltimore, 6/23/95

clxxxix Interview with Dr. Gerard Anderson, Johns Hopkins School of Public Health, Baltimore, 6/22

For the time being, the rate setting policy idea retains its hold. While the alternative idea -- in the form of the free market -- is recognized and understood, we can also discern clear signs of its non-acceptance in the state. (YES)

P3: In deregulated states, we should observe altered institutional structures to account for the demise of the old idea and the ascension of the new one.

Massachusetts: Several significant changes in institutional structures accompanied the rate setting deregulation in Massachusetts that was enacted in 1991. First, the hospital finance division within the Rate Setting Commission lost its authority to monitor and regulate hospital changes within one year after the enactment of the statute. A loose set of hospital-specific limits were established that ultimately affected only one of the more than 90 acute hospitals. The Commission has attempted to carve out a new role for itself as the data gatherer and disseminator of information, reports and analysis on the Commonwealth's health system. These reports have included one on preventable hospitalizations and another evaluating trends in HMO premiums. But the overarching role for the hospital finance division within the Commission is now history.

Equally important has been the rise in structural and independent authority of the Medicaid program. Raised from a division within the Department of Public Welfare to a special division in the Secretariat of Health and Human Services, the program now has complete authority to negotiate rates of payment with acute hospitals, and to avoid any oversight from the Rate Setting Commission.

Newly established was the Hospital Payment Advisory Commission (HOSPAC) to report to the Administration and the Legislature on various aspects of the new deregulated system, including fair marketing standards and the treatment of disproportionate share hospitals. HOSPAC was governed by a five member commission appointed by the Governor, and run by a professional staff. The organization was never able to establish itself as a strong voice in the health care environment, and was formally dissolved in the summer of 1995 as part of the fiscal year 1996 state budget.

Other changes accompanied the 1991 legislation, including a shift in the administration of the state's free care pool to the Department of Medical Security from Blue Cross, and changes in the structure of mental health programs. But the first two changes are most important in the context of this analysis. The overt hand of state regulation over hospitals was lifted; and the state agency most involved in the expenditure of health dollars for medical services, Medicaid, saw a shift in its statutory definition to move from being a payer to a purchaser of health services. Both of these changes are consistent with the shift in policy ideas reflected in hypothesis P1. (YES)

New Jersey: Three key structural changes accompanied New Jersey's rate setting deregulation enacted in 1992. First, as occurred in Massachusetts, the Rate Setting Commission within the Department of Health saw its hospital oversight functions eliminated, and the Commission itself is now defunct.

Second, the legislature established a new entity (with considerably more authority than the Massachusetts creation, HOSPAC) called the Essential Health Services Commission. The tasks assigned to the 14 member EHSC included administration and oversight of the newly formed Uncompensated Care Trust Fund, as well as oversight of the new reforms to the small group and individual health insurance markets. Separate advisory boards were also established within the EHSC to regulate the rules within those two distinct insurance markets. Because the compromise funding source for uncompensated care agreed to in 1992 -- \$1.5 billion from the surplus in the State's unemployment insurance trust fund -- was only established for three years, a controversy opened up in the State at the end of 1995 over replacement funding for the pool. As of this writing the controversy has not been settled. Controversy has also enveloped the EHSC, which was recommended for disbanding by Governor Whitman, with its duties to be assigned to the Department of Health. Nonetheless, the enacted structure and mission of the EHSC -- along with the elimination of Rate Setting -- was consistent with the policy

direction embodied in the replacement idea, namely, the shift from regulation of providers to support for insurance purchase by individual health consumers.

The other structural change, less prominent than in Massachusetts, was the unshackling of Medicaid's ties to the rate setting structure. Because the State's Medicaid program was not in a position to move aggressively into managed care, the change provided enhanced program flexibility, but not major structural change. (YES)

New York: Because rate setting deregulation has not yet been enacted by the Legislature, there is not evidence of broad based structural change that is yet observable in New York state government. However, some important modifications have occurred the 1995.

One important change that is strikingly apparent is the abandonment of the Department of Health and its Office of Health Systems Management by the vast majority of officials who ran the NYPHRM system for many years. These individuals have moved onto other positions, some finding employment in the hospital community. But this development is more the presage of change rather than the change itself.

Similarly, the New York Commissioner of Health, in her Task Force recommendations on the future of New York's financing system, suggests one version of the shape that the system could take, including: a new, but largely undefined role for the Department of Health in overseeing system quality and access to health plans by consumers; a new structure for collecting and managing funds for uncompensated care and graduate medical education; and the gradual elimination of public funding for hospital capital needs. Again, these changes are proposals rather than statute, but they indicate the likely direction of state policy as of the writing of this study.

One structural change that has already occurred has been the decoupling of Medicaid and Blue Cross reimbursement rates, joined tightly together since 1969. This change, more than any other to date, signals the near-certainty of rate regulation's demise in 1996. In essence, if the State's own health purchasing program needs the freedom to

contract and establish negotiated rates, there is no rationale to provide private sector plans with less leverage in the market. Once more, though, this change signals the major breaks to come, rather than completely establishing them. (*MIXED*)

Summary: Altered, created, and abandoned institutional structures are most clearly in evidence in Massachusetts and New Jersey. Additionally, these changes can all be tied in a convincing fashion to the shift in the prevailing policy ideas. While major structural changes are not yet in final evidence in New York, changes in Medicaid, along with proposed changes in the Department of Health, and staff desertions signal that institutional alterations in the near future should come as a surprise to no one. (*YES*)

P4: In Maryland, we should observe no similar institutional change.

It would be inaccurate to characterize the Maryland rate setting system as static. Throughout its more than 20 year history, the regulations and the central reimbursement formulae have been subjected to significant alteration and change. Indeed, in the current environment, the Health Services Cost Review Commission is now experimenting with its most ambitious form of change in its decades long history, attempting to permit forms of capitation and alternative payment methods within the rate setting methodology. However, rather than seeing these changes as comparable to the seismic structural transformations evident in the other subject states, the Maryland shifts fit much more comfortably into the punctuated equilibrium model's definition of deliberate incrementalism that characterizes continuing control by the prevailing policy monopoly:

During the reign of the prevailing policy monopoly, the system is subjected primarily to negative feedback, and initial disturbances become smaller as they work their way through the system over time. The internal and external system managers are able to accommodate and win over critics by making necessary concessions and changes to avoid more serious dissension. Only when a system becomes the object of positive feedback -- where disturbances grow in magnitude to become major disruptions over time -- does the system itself face potentially fatal threats.

In 1995, for the first time, serious questions were raised about the future of the Maryland system, from some HMO and business leaders. The Legislature responded by establishing the special review committee that has been mentioned previously. In doing so, they included a preamble with a ringing defense of the Maryland rate regulation system that gives no indication of waning support from key political leaders in the State. Thus these disturbances at this time appear to characterize the dynamics of negative, more than positive feedback.

In the past 20 years, there have been no institutional changes affecting the basic hospital finance structure that represent a threat to the role and authority of the HSCRC. As such, we observe sufficient support for the hypothesis. (*YES*)

P5. In deregulated states, we should observe the emergence of new players who, by broadening the scope of conflict, undermined the rate setting policy monopoly.

Massachusetts: New players in 1991 in the hospital finance sweepstakes in Massachusetts could be found both inside and outside of state government. Inside government, the new players could be found in both the Administration and in the Legislature. The key change inside government was the ascension of William Weld as Governor, bringing a different approach to governing and a special appreciation for the value of markets in approaching public policy problems. His key advisor, Charles Baker, was recognized by nearly all interviewees as central to the rate setting deregulation debate. Though the initial Administration bill only called for a three-year phase out of regulation, his approach emboldened all pro-market forces to advocate aggressively for full rate setting deregulation.

Inside the Legislature, key changes included the appointment of Thomas Finneran as Chairman of the House Committee on Ways and Means, and Carmen Buell as House Chairman of the Joint Committee on Health Care. Both rejected the earlier approaches that favored continued regulation. Finneran, in particular, broke with all prior bills by

releasing from his Committee legislation to deregulate the finance system within one year. Because both were Democrats, they brought along a party that otherwise could easily have supported continued regulation. While the key leadership positions in the State Senate went unchanged in 1991, the number of Republicans rose from 8 to 16 in the 1990 state elections, giving Governor Weld an important margin that could allow his vetoes to be sustained without Democratic support, another new element that altered the balance of power inside state government.

Outside government, the key changes could be found in the insurance community. The Massachusetts Association of HMOs was the only interest group that advocated deregulation consistently for a number of years. Their executive director, Robert Hughes, was well connected with the new Administration, and pushed deregulation at every opportunity. At Blue Cross of Massachusetts, a new top management team took control during 1990 and 1991, more market and business oriented, and willing to part from the standard support provided to rate regulation over many years. Parting from this support also meant parting from their extra charge differential over commercial payers -- but this was not an obstacle in the face of fierce and growing pressure from HMOs. Taken together, this combination of new players helped to change the face of health care financing in Massachusetts. (YES)

New Jersey: The most important new actors in New Jersey would also be found inside state government. In the Administration, Governor Florio and his key policy advisor, Brenda Bacon, would have to be counted among the new players. Throughout the first two years of his governorship, Governor Florio expressed his discontent with the shape of the health care landscape, particularly the high uncompensated care surcharge and the awkwardness and complexity of the rate setting system. Earlier commissions had recommended changes in health finance that the Governor was not able to get through the Democratically controlled legislature. Even before Judge Wolin's ruling in May, 1992,

Florio had been promoting health system changes to deal with the alarming rise in the number of uninsured residents, and to correct problems in the insurance market.

Also important were the new leaders of the New Jersey Assembly and Senate. As a result of voter rebellion in the wake of major tax increases in 1990, the electorate gave control of both branches to the Republicans in the 1991 elections for the first time in more than a generation. The new Republican leaders, especially Speaker Charles Haytaian, saw their elevation as the long-awaited opportunity to blow up the DRG rate setting structure. In the event that Governor Florio had wavered in his determination to eliminate rate setting, the new legislative leaders would have insisted on deregulation as the price of any other legislative concessions. Noteworthy to recall are the sentiments of Senator Richard Codey, Democrat, and former Chair of the Senate's Health Committee, who indicated his intention to modify -- but not deregulate -- the rate setting structure had Democrats held onto control in his Chamber in 1991.

In the external environment, the emergence of new players was less apparent. The HMO Conference was clearly a new player, but did not pretend to bring major clout to the table. The only two interests that could potentially be labeled as new would be: first, the building trades unions which began to see their interests as no longer aligned with continued rate setting because of the financial burdens on them through the uncompensated care surcharges; and second, the federal district court -- definitely an example of an expanded scope of conflict -- which weighed in on behalf of the unions by declaring the surcharge to be a violation of the federal ERISA law. Though Judge Wolin's ruling was thrown out one year later by the Court of Appeals, during the six months after his ruling, he monitored developments in the Legislature closely, and made clear his intention to hold the State to the November 30, 1992 agreed upon timetable to find a replacement source of funding for uncompensated care.

The emergence of Governor Florio and the new legislative leadership is the strongest example of new players who helped to change the environment. A new attitude

on the part of labor and the emergence of the federal court as a player, are additional examples of the emergence of significant new players. *(YES)*

New York: There is only one place where a new set of players has shifted the landscape relative to the future of NYPHRM -- but it is arguably the most important place, and that is in the Governor's Office. The departure of Governor Mario Cuomo at the end of 1994 signaled the end of a long era of expansive regulatory outreach and control not just in health care, but throughout state government. Newly elected Governor George Pataki has demonstrated his eagerness to embrace deregulation wherever possible throughout the expansive New York state bureaucracy. His new Commissioner of Health, Barbara DuBuono, has made public her recommendations for an end to NYPHRM style rate setting. They have submitted proposals to the Legislature for changes in financing of uncompensated care, graduate medical education, capital funding, and other access programs in order to facilitate an orderly transition.

There is disagreement among interviewees on whether deregulation would be under consideration in the same way had Governor Cuomo been re-elected. Some argue that the changes in the health care landscape would have compelled the same dialogue and determinations now being made. Others suggest that Department of Health staff were already preparing for only modest revisions for a NYPHRM VI had Governor Cuomo remained. It seems likely that the marketplace changes in the State would have compelled some significant alterations, but whether a scrapping of NYPHRM would have occurred under a fourth Cuomo Administration is unknowable. What is clear is that the ascension of Governor Pataki opened the door to a broad and fresh re-evaluation of NYPHRM that could easily have not occurred under the other set of circumstances, a change that had considerable effect on the prospects for continued rate setting.

No major changes have occurred in the Senate or the Assembly. Most of the leaders of the various interest groups are the same. The change has not been in new characters, but in individuals and organizations moving away from long and deeply held

positions -- groups such as Blue Cross, LICONY, the State Communities Aid Association, the Business Council, and others. A change in long-standing policy position by key groups is also consistent with the hypotheses of the punctuated equilibrium model. While the strength of the observation is not as clear in New York as in the other two states, it is still apparent that the emergence of new actors in the Administration and the change in positions by other groups have helped in important ways to shift the dialogue and prospects concerning continued rate regulation in New York. (YES)

Summary: The overall evidence strongly suggests that new players (and new positions among old players) emerged in all three states in ways that were vitally important in undermining long standing support for continued hospital rate regulation. (YES)

P6. In Maryland, we should observe either no new such players, or clear indications as to their ineffectiveness.

There are new players in Maryland, but no partisan shift such as the ones that opened the door for changes in the other subject states. A new Administration under Governor Parris Glendening, including a new Commissioner of Health, has led to no significant alteration in views on the Maryland rate setting system. With eyes on the federal dollars associated with the Medicare waiver, Administration officials and policy makers on health matters refuse to make any changes that could jeopardize the continued flow of Medicare funds into the state's hospital industry.

The HMO industry, because of its size, is a recognized player that is somewhat new. HMOs have enjoyed huge growth in penetration in Maryland since the late 1980s. Some of the out-of-state based for profit HMOs, especially New York Life's Health Plus, have weighed in on the debate, openly suggesting that the State should abandon the rate regulation scheme. However, the HMO Association has explicitly not called for deregulation, and will be very careful before making any such move. And public officials are openly disdainful of the calls by Health Plus leaders for a move away from regulation.

Aside from the HMOs, the players in labor, business, Blue Cross, and commercial insurers are essentially the same. While some will raise questions about the ability of the rate setting model to sustain itself in the long run, none has yet broken ranks and advocated explicit deregulation. Thus far, the Health Plus chief, Jeff Emerson, is standing largely alone, without even the support of his state association.

All of this could change. A loss of the federal waiver, a major shift in political control in the legislature or the executive branch, or some other shift in federal policy -- any of these or more could lead to a rapid change in consensus. Clearly the loss of the federal waiver would lead to major reconsideration -- and quite possibly rapid deregulation. But for now, the judgment is clear: there are few new players calling for deregulation, and no indications that they are being effective. *(YES)*

Notes to Chapter VI

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CHAPTER VII

CONCLUSIONS

“As someone who views ideas as valuable, and not someone who thinks that everything happens because of interest group determinations, I have been sobered over the past few years about how important it is for ideas to fit into a framework that fits for certain interested parties.” ^{cboxx}

As has been apparent since chapter one, this study is about more than one thing. It is about mandatory hospital rate setting in four states, and what its continuation or deregulation can tell us about health policy in the 1990s. This study is also about two theoretical lenses -- the theory of economic regulation and the punctuated equilibrium model of policy development -- and what they can tell us about economic, political, and policy phenomena. Finally, this study is about the broader and deeper interplay between interests and ideas as engines of policy development and change. Both have always been with us, in varying degrees, and both always will be.

The purpose of this chapter is summarize the key findings in each of these three areas, to discuss their significance, and to identify areas for future research and investigation.

Key Findings: Rate Regulation and Deregulation

Three patterns require summarization and discussion at this point. First is the observable pattern associated with deregulation in Massachusetts, New Jersey, and New

^{cboxx} Charles Baker, former MA Undersecretary, Health and Human Services

York that explains why that policy option was exercised. The second is the counter-pattern observed in Maryland that explains why continued rate setting regulation remains a viable policy choice. The third is the overall set of lessons for health policy that can be learned from the rate setting experience in the subject states.

Why Rate Setting Deregulation Happened in Three States: While the intensity of each factor varied from state to state, the following five factors were the critical variables that accounted for or accompanied the move to deregulation:

The Collision with Managed Care: The rate setting policy idea was directly related to the belief that the health financing system in the subject states was a classic example of market failure. The providers, chiefly the hospitals, held all the advantages and leverage, while the key payers (government, business, insurers, and labor) held none. The prevailing reimbursement system of cost-based, retrospective payments was based on inflationary and inefficient incentives. The only entity capable of confronting effectively the power of the providers was government, using its legal authority with the backing of business and labor.

The insurgent policy idea that emerged on a national level in the late 1970s, but failed to appear in the states until the late 1980s, was that market failure was a transitory phenomenon, not a permanent reality. The time lag can be attributed to the lengthy period required for managed care to reach a point of critical mass in the subject states, as well as the normal lag time for policy makers to perceive a need to address these changes. During the rate setting epoch, businesses, insurers, and labor used their growing power to reorganize the framework of the health care financing system. By adopting a paradigm shift that changed their mode of thinking from one of being a *payer* of health services to being an active *purchaser* of services, they could exert market pressures far more effectively than government to lower prices rather than just to lower the rate of increase in the charges for hospital services. By reorganizing their methods of operation, prudent

purchasers could address not just the rise in inpatient hospital costs, but also the increase in overall health costs as well.

Whether this perception is true in the short, medium, or long term is beyond the scope of this investigation. What is germane and clear is that important interests with both economic and political leverage in the states embraced this view with enthusiasm in the decade 1985 to 1995.

The key instrument for this transformation was managed care in general, and the health maintenance organization in particular. Managed care, in the form of micro-level negotiated rates of payment between purchasers and providers, fundamentally changed the dynamic that had existed previously in the health system. Health maintenance organizations were the most visible manifestation of the transition, as well as a political force willing to provide leverage in advancing systemic change.

In our subject states, the desire of the HMOs to engage in negotiated rates of payment with hospitals significantly undermined the logic and appeal of governmentally mandated rates of payment. The growth of HMOs, particularly in Massachusetts in the late 1980s and in New York in the early 1990s, created an uneven playing field that threatened the financial and organizational stability of Blue Cross plans in both states. The strong desire of Medicaid programs in both states to begin using their market share to leverage lower rates of payment created further and immense pressures on the regulatory system. While HMO development in New Jersey was not strong enough to destabilize that State's system, interviewees clearly indicated their hope that deregulation would encourage the rapid growth in managed care that was evident in other states -- an expectation that has in fact occurred in that state since deregulation.

The Link to Political Change: Political change from Democratic to Republican control did not always lead to abandonment of hospital rate setting. In 1981, Republican Governor Thomas Kean's election as New Jersey Governor led to a continuation of that State's DRG system implementation. Indeed, had Kean not been elected, it is entirely

plausible that the State would have lacked sufficient political leverage to convince the Reagan Administration to renew its Medicare waiver, a development that could have doomed the system much earlier than 1992.

Nonetheless, each deregulation in the three subject states was accompanied by an immediately prior shift in political control: Republican William Weld's election as Massachusetts Governor in 1990, the shift to Republican control of the Assembly and Senate in New Jersey in 1991, and the election of Republican George Pataki as New York Governor in 1994. There is evidence to suggest that these deregulations might have occurred anyway -- each was accompanied by major health market changes along with some legislative trigger (legislative sunsets in Massachusetts and New York, a federal court mandate in New Jersey). And key Democratic Party support was in evidence in both Massachusetts (Finneran, Buell, Burke, McGovern) and New Jersey (Florio) in both States' deregulation initiatives.

Nonetheless, the shift in political control served as an important opportunity and "focusing event" [1] for deregulation advocates inside and outside of state government. The change significantly emboldened those seeking to change the system to push beyond what might otherwise have been considered possible. Continued Democratic Party dominance could have signaled a call to key parties for only status quo refinements to existing regulatory frameworks. This element of rate setting's fate also confirms a hypothesis from 1963 made by Lowi who found that new departures in policy are more likely at the beginning of a new administration, especially when a former minority party gains control of the government. [2]

The Incomprehensibility Factor and Regulatory Failure: There is clear evidence that the rate setting systems in the subject states were effective in constraining the rate of growth in hospital expenses in the early years of those system and up until about the mid-1980s. The empirical research and data described in chapters two and four demonstrate

that mandatory prospective rate setting outperformed non-regulated systems in other states in holding down the rate of growth of inpatient hospital costs.

This success in cost control laid the groundwork for later failures. Regulators and legislators responded to intense negative feedback from hospital officials to make significant concessions in reimbursement policies in a manner that supports in many respects the “capture” predictions of the theory of economic regulation. While New York regulators were able to hold onto long-term and highly professional staff, regulatory agencies in Massachusetts and New Jersey saw rapid turnover and demoralization among those charged with maintaining the day-to-day operations of the system. To respond to the complaints of various hospital officials and their legislative allies, regulations and statutes were adjusted to make them even more complex and incomprehensible than before. The administration of the rate setting system became more and more an insider’s game, conducted by a very small circle of players that had the only sophisticated understanding of its workings from a legal, financial, administrative, or historical perspective.

In Massachusetts, the statutes were compared with Sanskrit. In New Jersey, the program operated “like a Methadone program.” In New York, the complexity provoked “considerable black humor.” In each case, the image of incomprehensibility and the perception of widespread gaming both worked to undermine the commitment of the key supporting parties in continuing what appeared to be a bad and worsening regulatory experiment. As the RAND analysis of the New York NYPHRM model concluded, regulatory systems defeat themselves if the incentives are so complicated that even the most conscientious managers can never fully understand them. [3]

The Changing Interest Group Landscape: Rate setting did not develop in the subject states as the result of any sort of mass citizen mobilization. Rather, it was adopted because of the direct self-interest efforts of key power constituencies.

In Massachusetts, the key groups were legislative and administration officials looking for the most effective means to control rising Medicaid expenditures, business officials seeking protection from rising costs, Blue Cross and commercial payers seeking protections against cost shifting, and hospitals at various points seeking to avert the federal PPS rules. In New Jersey, the key parties were governmental officials seeking hospital cost containment, along with labor, business, and insurance officials seeking financial protections from the concentrated economic power of hospitals. In New York, the key players were the Executive and Legislative branches, Blue Cross, commercial payers, and business. While disputes and battles marred the overall harmony of these key interest groups, none could be observed during any early phases advocating deregulation or market solutions -- and, in fact, they frequently promoted more aggressive governmental regulation.

The rate setting deregulations in all three subject states were accompanied by significant alterations in the interest group landscape. Administration officials sought to be free of rate setting constraints so that Medicaid programs could utilize their market leverage to lower public rates of payment. Business leaders saw the ability to engage in competitive discounting as a strategy to actually lower hospital costs that they felt were artificially high and to force the elimination of excess hospital capacity. Blue Cross and commercial payers desired to have the ability to compete on a level playing field with HMOs who were no longer a tiny, marginal part of the market, but instead the engine reshaping much of the system. And finally, groups of suburban and community hospitals felt shut out of the "inside circle" of rate setting regulation, and run over by their wealthier and more influential academic medical center counterparts.

The new players, associations of health maintenance organizations, were supportive of deregulation, primarily because they feared an alternative of tighter regulation that would limit their discounting capabilities. However, in the three subject states, none were powerful enough to be major players in behalf of deregulation. More

prominently, their mere presence and growing market share was a striking symbol of how much markets and political dynamics had changed.

Picking Up the Pieces: A characteristic feature of deregulation in the three subject states was a serious, and sometimes controversial, effort to preserve systemic elements that accompanied rate regulation, primarily uncompensated care funding.

In Massachusetts, the end of rate setting meant the end of an easily assessed surcharge on hospital charges. With the advent of full and aggressive negotiated contracting, and very few payers left who paid full charges, the surcharge on payers became a backdoor assessment on hospitals. The funding for the pool remained capped at the 1988 level of approximately \$300 million, but because bad debts were no longer reimbursable, hospitals were able in 1991 to collect all of their allowable charity care charges. The funding for the pool remains capped at about \$300 million at least through 1996, and hospitals are now recouping less than two thirds of their documented charity care needs. Moreover, in the increasingly competitive contracting environment, the surcharge increasingly functions more as a hospital revenue tax, leaving those institutions less supportive of its continuation. Most importantly, the critical motivation for policy makers to retain the Pool in 1991 was its newfound capacity to generate federal disproportionate share matching funds in the hundreds of millions of dollars. Indeed, the retention of the Pool seems to have served State financial interests far more than the needs of the uninsured or hospitals.

In New Jersey, the raging battle in 1992 over replacement funding for the Uncompensated Care Trust Fund was waged with full awareness of the substantial federal financial stakes involved. Overall funding for charity care was cut substantially -- though the system was so bloated by 1991 that some trimming seemed reasonable. In addition, the state maintained continued financial support for hospitals with Medicare shortfalls for one year. The clear intention on the part of the Florio Administration was to move available funds from hospital reimbursement to insurance subsidies for uninsured persons.

As of the writing of this study, Governor Whitman and legislators have not come to agreement on a replacement source of funding for the Trust Fund that expired on December 31, 1995.

In New York, the controversy over funding not just for uncompensated care, but also for graduate medical education, hospital capital needs, and the variety of health access and planning functions that have been tied to the NYPHRM regional pools is the reigning concern in the months leading up to the deregulation debate and legislative action. The Health Commissioner's Task Force report to Governor Pataki in December, 1995 and the Governor's legislative proposals in March, 1996 both recommended continued funding for most purposes except hospital capital needs, though all at reduced levels from current funding. Most interviewees expressed serious concerns about the financing sources and distribution of benefits in any replacement system.

Thus we can observe in all three states continuing commitments to access needs that were met under the rate setting regulatory structure. Generally, the funding levels represent a decrease from resources available during the regulatory period, and include much tighter controls on expenditures. An important part of this continued commitment has been the ability to use these revenue sources to leverage federal matching funds. If significant changes in the federal Medicaid system -- such as discontinuation of disproportionate share hospital funding -- are made, each State's commitment to hospital access for the uninsured once again will be severely tested.

Anticlimax: In none of the three deregulated states could the process of deregulation be termed as peaceful or serene. In Massachusetts and New Jersey, there were voices advocating continued rate regulation in a different form who clamored for and received attention. In New York the debates around the deregulation legislation promise to be strenuous and controversial.

But overall, the state decision to stop setting rates -- as opposed to the other related issues in deregulation legislation -- cannot be ranked as legislative controversy of

the first order, and actually seemed fairly tame. In Massachusetts, consumer groups, labor, and supportive academics were overwhelmed in the House of Representatives by supporters of deregulation; in the Senate, no opposition surfaced at all. In New Jersey, the sharpest fights emerged over the use of Unemployment Insurance Trust funds to finance the Uncompensated Care Trust Fund for three years. While some urban and academic hospitals made a fight for continued regulation, they did so with little or no support from any other quarter. Similarly in New York, the prevailing attitude among interviewees and interest groups is that continuation of the rate setting functions of NYPHRM is a lost and unworthy cause.

When all was said and done, the rate setting function seemed more than a little like the old dead tree in the back yard that someone finally suggested should be taken down. For most interested and semi-interested parties, it was hard to disagree.

Why Rate Setting Continues in Maryland: The same framework used to explain the reasons for rate setting deregulation in Massachusetts, New Jersey, and New York is also helpful in explaining why Maryland policy makers have chosen to retain their unique system.

The Collision with Managed Care: Managed care penetration has grown in Maryland since the mid-1980s at a fast rate, with the state having the third highest proportion of residents in HMOs in 1993. This development contradicts a large volume of predictions about the impact of rate setting on the growth of alternative delivery mechanisms such as managed care. Analysts who opposed rate setting as a cost control mechanism in the late 1970s and early 1980 confidently predicted that rate setting would thwart managed care development. There is no evidence to suggest that this occurred in Maryland (or Massachusetts and New York, for that matter) -- a state that has successfully maintained tight controls on discounting by all payers, including HMOs.

Despite this growth, the Maryland system has not experienced the collision with managed care that occurred in the other three subject states. Managed care organizations

complain about the constraints of rate setting, to be sure, and a few even argue for its elimination. But none can complain that the system has held them back -- and the state HMO Association remains cautious in expressing reservations about the rate setting program.

Meanwhile, rather than attempting to hold onto an outdated model, officials at the Maryland Hospital Cost Review Commission are working to develop new models of rate setting that permit global and capitated payment mechanisms. Some of these models are already in operation in select hospitals, with expansion plans underway. The result of this activity is that regulators and their sponsors can legitimately claim to maintain a regulatory model that adapts to changing circumstances in the health sector. An important reason why regulators can make these adjustments is the considerable latitude provided to them in the rate setting enabling statute.

The Link to Political Change: Political change of the sort that shortly preceded deregulation in Massachusetts, New Jersey, and New York has not occurred in Maryland. Democrats retain control of the Executive and Legislative branches, and indicate no desire to change course with regard to their 25 year old hospital rate setting program. The 1994 gubernatorial election, the closest such race in the nation, had the potential to destabilize the rate setting policy monopoly in the state, though interviewees were not certain how defeated Republican candidate Ellen Sauerbray would have moved on matters relative to rate setting.

Both branches of the Legislature remain under Democratic Party leadership. The point persons on health policy in both branches have long histories of support for the program and indicate a distinctly negative attitude toward suggestions for deregulation. The leadership in both branches and in the Department of Health express significant "trust" for the regulators who run the HSCRC, even to the point of admitting that they have little sophisticated understanding of the program's workings. That trust is most tangibly expressed in an enabling statute that has had no significant modifications since

1971. It is also an enabling statute that provides enormous leeway to the HSCRC regulators to respond to negative feedback and to modify the system in major ways to adapt to changes in the external health system environment.

The Incomprehensibility Factor and Regulatory Failure: To be sure, discussions about hospital rate setting in Maryland are not broad, participatory discussions for mass audiences. The details can be mind-numbingly complex. But HSCRC administrators have been able to hold onto, articulate, and communicate the key set of principles that have guided their work since the early 1970s. The program's statutory and regulatory flexibility has been invaluable to regulators in addressing criticisms and adapting the program to changing external developments. While a number of interviewees express dislike for the "policy idea" that underlies rate setting, none would go so far as to hold the program up as an example of regulatory failure.

The one key regulatory criticism made by some has been the lack of coordination among the three special health commissions, including the HSCRC. The legislature made moves to address this complaint in 1995 by mandating closer cooperation and collaboration among the three entities.

The Changing Interest Group Landscape: The glue that holds the coalition of interests together in support of continued rate setting is clearly the Medicare waiver that brings to the state an estimated \$200 to \$300 million in federal funds that would be lost in the absence of the waiver and rate setting. Even groups such as some business leaders and insurance/HMO officials who express newly discovered distaste for hospital rate regulation are careful in their expressions because of fear for the adverse financial impact that would be associated with the waiver's loss.

The hospital leadership remains strongly in support of the program, even as some smaller hospital officials express misgivings. Blue Cross, commercial payers, and the HMO Association all articulate misgivings, and clearly would not mourn the departure of the system, but do not want to be associated with the financial consequences that would

accompany the waiver's loss. The business community expresses some misgivings, and supported the "fresh look" endorsed by the Legislature during the 1995 session. The labor community remains strongly in support. Despite the misgivings of some, the disintegration of interest group support that preceded the other deregulations is not in evidence in Maryland.

The final two themes that described the deregulations in the three subject states -- *picking up the pieces* and *anticlimax* -- are not relevant to the Maryland situation.

In summary, a unique combination of factors -- financial, statutory, political, cultural -- have combined together to make continuation of Maryland's unique regulatory model a viable and reasonable option. But it also should be equally clear -- given this unique and unlikely blend of circumstances -- why Maryland stands alone and is likely to do so for the foreseeable future.

Key Lessons from the Rate Setting Experience

Though Maryland continues an all payer, mandatory rate setting program, it is appropriate to propose summary judgments on the state rate setting experience for health policy makers and for health policy generally. Four principal observations, based on the analyses in this study, stand out.

First, the deregulation of state-based mandatory rate setting represents more an evolution in prospective payment methodology than an anti-regulation revolution or a return to a prior era.

Some interviewees viewed the rate setting deregulation experience as an explicit rejection of governmental regulation in general and in the health sector in particular. Given the anti-regulatory climate that has prevailed nationally since the late 1970s, as well as the strong distaste expressed by many key interest groups for the way that mandatory rate setting evolved in the subject states, this conclusion seems plausible.

An alternative view is grounded in an analysis of the 30 year evolution in how hospitals get paid for their services. Prior to the enactment of rate setting models in the states, the prevailing payment form was retrospective, cost-based reimbursement for "usual, reasonable, and customary" charges. Broad dissatisfaction was evident in the 1960s and 1970s with that payment form, viewed as inflationary and loaded with inappropriate incentives for hospitals to do more and to charge more for their services. These concerns were heightened by the creation of the Medicare and Medicaid programs.

The alternative policy idea that emerged became known as prospective payment -- determining in advance a rate at which hospitals would be reimbursed, establishing predictability for both payers and providers, and removing some of the least efficient incentives associated with the retrospective system. Because costs associated with inpatient hospital services were the largest category in the health care dollar at that time, and because policy makers believed that excessive use of these services triggered the expenditure of many more dollars into the system, this area of spending became the locus for cost control. Because government was the only part of society at the time believed to hold sufficient leverage over the hospital provider community, all other key interests -- business, labor, insurers -- supported the use of government power to enforce the new regulations.

The first prospective payment methodology used was per diem reimbursement, establishing a set level of payment for each day of hospitalization. While the imposition of this control is credited with reducing the rate of growth in hospital expenditures, its own set of inappropriate incentives -- including ones that led to increased lengths of stay -- was soon apparent, and triggered the search for more effective cost control mechanisms. The New Jersey SHARE program as well as the first two versions of NYPHRM were prominent examples of this form of payment control.

The replacement cost control mechanism was per case or per diagnosis, or more specifically, diagnosis-related groups that eliminated incentives to extend artificially the

hospital length of stay. DRGs also provided incentives to reduce the intensity of services provided to patients once the diagnosis was apparent. Pioneered in New Jersey, the method spread to the national Medicare system, and to other rate setting states such as Maryland, Massachusetts, and New York (albeit not until 1989). The Medicare Resource Based Relative Value Scale (RBRVS) is the extension of per case prospective payment methods to physician services.

But the limitations of the per case cost control method also became apparent. Chief among them was the focus of regulation on inpatient hospital costs even though the locus of service had begun to shift rapidly out of the hospital. Also, while governmentally sponsored regulation was able to reduce the rate of growth in charges, it proved unable to force reductions in actual costs that some observers began to see as necessary and possible. Further, the complexity required to administer these systems led to substantial gaming and political maneuvering on the part of hospital that often negated successful cost control influences.

The next stage of prospective payment regulation, capitation, differed from the prior two approaches in two important ways. Capitation -- or prepayment for covered lives instead of for days or diagnoses -- allowed for financial control of all health spending, not just inpatient hospital costs. Also, the more effective regulatory control mechanism was thought to be private and public sector purchasers of services instead of independent government regulators.

Thus the advent of government rate setting deregulation does not signal a return to an earlier era when payment control mechanisms were non-existent or primitive. Rather, it reflects a transition from per diem and per case prospective payment to capitated prospective payment, and the shift in regulatory control from government rate setters to purchasers. Ironically, in some respects, the new structure resembles the way that Maryland hospitals were treated by Maryland Blue Cross before state rate setting was established in 1971. Once again, hospitals face arbitrary treatment at the hands of payers.

Increasingly, across the nation, they chafe at the new form of constraints as bitterly as they complained about rate setting regulators. This time, the controls involve more payers, the treatment is rougher, and there is no other place left to which they can shift costs.

Second, the near-end of the rate setting experience signals a different and more limited role for state government in health sector regulation.

While the evolutionary aspect of deregulation should be recognized, it is also clear that this change represents both a rejection of the role of government as a price setter and an explicit move toward more market-based mechanisms. This is entirely consistent with larger trends observable in government in the 1990s at the federal, state and local levels.

The architects of rate setting systems were most often passionate believers in the role of government as the driver of health policy in each state. Frequently, they envisioned hospital rate setting as an evolutionary stage leading to stronger and more expansive state controls, including forms of single payer systems. Indeed, DoH officials in New York during the late 1980s and early 1990s spent considerable time developing a proposal known as UNY*CARE that would have made state government the single collector of all payments to hospitals from public and private sources, and also the sole payer of bills to hospitals. UNY*CARE now joins the pantheon of untried and untested health system reform ideas.

A clear casualty in the deregulation of state rate setting is the public utility model of regulation for hospitals. The all-encompassing role for states in directing health system financing and delivery is no longer up for discussion in the current environment. Perhaps in the future, a utility form of regulation will be required to control the new mega-health plan systems. But for now, public utility regulation of hospital has been largely abandoned.

However, the abandonment of rate setting does not lead to a cessation of state health system intervention. Massachusetts and New Jersey deregulations, for example,

were accompanied by an expanded role for state government in regulating the performance of the small group insurance market. New Jersey added to that a new program for those in need of the individual insurance market.

The focus is shifting -- from a regulatory model that placed hospitals at the center of the health system universe to one that focuses on insurance markets, the needs of individual consumers, and accountability for managed care health plans. As the health system moves away from a preoccupation with the hospital, so has the intensity of interest on the part of state government as well.

Third, the history of state hospital rate setting illustrates the substantial capacity of regulatory targets to game and manipulate reimbursement rules and financing incentives.

Under per diem and per case prospective payment, the gamers were the hospitals. Under capitation, the gamers are the managed care entities, especially the HMOs. The players are different; the rules are not quite the same; the environment is significantly altered. But the games go on.

Under state rate setting, the hospital community demonstrated an ability to learn the rules of the regulatory system better than any other affected interests, and to use their knowledge and political skills to win substantial concessions from regulators, legislators, or both. At many turns, the situation closely resembled Stigler's "capture" model. [4] The principal example of this occurred in New Jersey where regulators and legislators in 1991 simply threw up their hands and handed hospitals about \$1 billion in extra charge increases rather than attempt to resolve the thousands of outstanding appeals and retrospective settlement cases. Members of the Rate Setting Commission admitted an inability to comprehend the dealings between DoH staff and hospital finance officials, but perceived that the gaming was out of control.

In Massachusetts, the hospital industry went around regulators and won huge financial concessions from legislators through the new finance rules in the 1988 Universal Health Care law, chapter 23. More than 10,000 hospital workers rallying on the Boston Common, bused in at hospital expense, made the knees of legislators buckle under the constituent pressure. Even after the 1988 concessions, hospitals continued to form subgroups to file bills to seek special treatment, often provided in legislation to groups of hospitals as small as one. In addition, Massachusetts regulators saw the same problems of retrospective settlements that plagued the New Jersey system.

New York's NYPHRM system has a track record that has been far tougher on the hospital industry, leading to serious and periodic financial crises for vulnerable institutions. However, the trends evident in Massachusetts and New Jersey were also apparent in New York in the inside dealings between hospitals and the DoH rate setting staff. The rules of NYPHRM became so extraordinarily complicated, that only a very small cadre of inside players in hospitals and DoH understood the real workings, much less the actual incentives provided to institutions.

So what lessons does this experience hold for today?

As the nation's health system moves headlong into new capitated forms of payment regulation, particularly in the federal Medicare program, we can expect the behavior of the new regulatory targets to mimic that of hospitals in important respects. One interviewee, in particular, made this important connection:

"We have millions from HCFA to study capitation. But in many ways it's the same methodology as rate setting. The problems are exactly the same. We're concerned about gaming, predictive accuracy, and administrative feasibility. When we set rates for capitation, how do we identify the people so that they are paid for the same level of illness. Because of the experience with rate setting and hospitals, we are forewarned that the HMO industry will play with the risk adjustment methods. We are aware that we can do something administratively quite elaborate to address it; but we are also aware of the system problems in terms of data limitations.

"What we have learned is how they're going to game. Sometimes you're right with the predictions and sometimes you're not. In 1978 and 1983, I helped to design the Carter hospital cost control bill and PPS. There were things we knew they would do and they did; but there were others that we never thought of that they did. But you find that you're right more often than you're wrong."^{cbccc}

The state rate setting experience should provide us with a renewed sense of caution and humility regarding the ability to states to implement and maintain complex and contentious systems. While the four subject states have been able to perform some impressive regulatory feats in establishing and running complex systems, their limitations are also important to keep in mind. The example of the New Jersey system, where the policy entrepreneurs who designed and set up the DRG system quickly left state service, and the system itself collapsed under the weight of its complexity, is matched by the bureaucratic problems encountered in Massachusetts and New York, where the system's complexity became a recurring source of black humor. It is also important to keep in mind that most state governments do not begin to compare with our subject states in terms of administrative capacity and depth, either legislatively or administratively. This limits the applicability of the mandatory rate setting model to other locales.

Fourth, the long experience with state prospective rate setting demonstrates the ability of states to meet some important policy objectives. (In other words, it wasn't a total failure.)

This final observation will strike some readers as in conflict with judgments two and three. Yet it is important to recognize that for as long as 25 years -- with widely varying ranges -- the four subject states were able to achieve multiple goals of reduced cost growth, improved access, and other important health policy objectives.

^{cbccc} Prof. Gerry Anderson, Johns Hopkins School of Public Health

We often view regulatory schemes and other public programs according to standards and expectations developed after such initiatives were created. With the advantage of hindsight and revised expectations, it is often too easy to conclude that the initiative missed the mark. In the case of rate setting, we should view these programs at least partially according to their ability to meet the purposes for which they were created: to reduce the growth in hospital costs, to reduce cost shifting among different payers, to stabilize threatened hospitals, and to improve access by uninsured persons.

In the case of Maryland, state policy makers have been able to achieve substantial changes in the cost performance of the hospital sector, significantly reducing the rate of growth on a per admission and per capita basis. That system has dramatically lowered the cost shifting among various payers. It has provided stability to the hospital industry and maintained a system of open access to hospital services for the state's uninsured population. It has done all of this with a regulatory structure that has continuously evolved over 25 years. It is and will remain an important point of comparison with states that have adopted aggressive competitive and market based health system strategies.

In Massachusetts, the rate setting system was able to reduce that State's rate of growth in hospital costs, the highest in the nation, significantly between 1975 and 1987. It developed a viable and controlled mechanism to assist hospitals in meeting their charity care obligations. It provided the means to keep vulnerable institutions such as Boston City Hospital viable in an era when other public hospitals began rapidly to disappear from the scene. The deterioration of the system after 1988 can be attributed to many factors, some within the control of policy makers and some that were not. But the mistakes that led to its collapse should not lead to dismissal of the system's accomplishments during the first two thirds of its existence.

In New Jersey, it is perhaps hardest to find the silver lining given the substantial deterioration that happened in the late 1980s and early 1990s. Perhaps it would be useful for public policy practitioners and students to study the New Jersey system to learn how

to avoid its mistakes in losing control. But New Jersey should also be remembered for the pioneering role it played in the development of diagnosis-related groups, an experience that directly informed rate setting developments in other states as well as prospective payment evolution for physicians and hospitals in the Medicare program. And it should also be noted that during the SHARE years and the early DRG years, the system was able to restrain the rate of growth below that experienced in most other states.

And finally, there is New York, the regulatory equivalent of a roller coaster, a system that was created to keep hospitals from the brink of financial catastrophe, and moved them back and forth from the edge over 20 years. The uncompensated care pools provided a level of access that did not and still does not exist in most other states, even though the funds were spent in a hugely inefficient manner. The system allowed the creation of a host of innovative and significant access and health reform programs that would not have found their way into the State's annual appropriations budget. The system provided a mechanism for all key interests to work together to plan for and meet important state health policy objectives. While we can judge NYPHRM by its failures, of which there were many, we may also do the same in the not too distant future when we evaluate our own current romance with the free market and unrestrained competition.

But when NYPHRM is viewed from the lens of the era in which it was created, recognizing its strengths and flaws, the final judgment may be different:

"If you go back to the mid 1970s or to the late 1970s ... hospitals were frantic over a growing problem in urban hospitals in dealing with uncompensated care. If I look at the 1978 chaos, and the fact that New York's health system has survived and that New York has still maintained the values of trying to provide care for the medically indigent population with all of its imperfections, and has continued to keep the system available, in that sense, I'm not sure that there was a better way to get from 1978 to 1995." ^{ebccci}

^{ebccci} James Tallon, former Assembly Majority Leader, current President, United Hospital Fund, Portland, OR, 8/6/95.

Suggestions for Future Research: Increasingly, the study of state-based hospital rate setting regulations resembles paleontology, combing over the bones and fossils of an abandoned and forgotten era in health policy. For those drawn to such pursuits, there is plenty of room for empirical examination of the rate setting era from 1985 to 1995. Virtually no empirical investigation has looked at this period in the states, relying instead on the 1970 to 1985 period when investigators found real evidence that hospitals costs in the subject states were lower than would have been expected in the absence of regulation. Analysis of data from the latter period may help to shed light on the reasons for the regulatory collapse in Massachusetts and New Jersey, as well as for the continued regulatory success in Maryland. Analysis may also help to understand the performance of the uncompensated care pools in the subject states, and the impact of these instruments in improving or hindering access for the uninsured. The pools are a useful example of the "public health" model of access subsidies, and would prove a worthy point of comparison to "insurance" models that have their own set of inefficiencies and problems.

Other investigations might look at the performance of the subject states, and other rate setting states, in the aftermath of deregulation. This is another neglected area of health policy studies. What actually happened in the deregulation era, empirically and politically? How did the hospitals and the health insurance markets respond, and how did this vary from developments in other states? These are questions beyond the scope of this study, but worthy of serious and critical examination. The current fascination with competition and the market in health care may give way to other approaches in the future as health markets become increasingly concentrated in the hands of a few large managed care organizations. It is possible that re-regulation will be presented as one possible intervention to address inadequacies in the future health markets. Further research on the post-regulation environment in rate setting states may inform policy judgments in the future.

Conclusions: Theory of Economic Regulation and Punctuated Equilibrium

We now turn to the theoretical models that have formed the core of this investigation. The basic research questions of this study, presented in chapter one, were:

What factors help to explain the demise of mandatory hospital rate setting in Massachusetts, New Jersey, and New York between 1991 and 1996, and the continuation of rate setting in Maryland? To what extent can these outcomes be explained by the theory of economic regulation and the punctuated equilibrium model of policy change?

This section summarizes the conclusions relative to the second question .

The theory of economic regulation provides some help in understanding the dynamics of the regulatory process and the role of interest groups. First, the theory directs us to ask the question, "who benefits," from the creation, maintenance, and destruction of the rate setting regulatory scheme. In particular, by compelling us to question the motives of both system designers and the regulated industry, we can see the dynamics of the regulatory process in a way that a pure public interest model would disguise. In particular, we are required in this model to examine the "capture" hypothesis, whether relevant or not, in a way that forces significant scrutiny and "truth-telling" onto the process. Using the theory of economic regulation leads us to ask useful and important evaluative questions, even if the result is to reject the overall relevance of the model.

But reject the model we must. The evidence that state rate setting systems benefited hospitals more than consumers is weak. In Maryland, the evidence is non-existent, and in Massachusetts and New York, it is sparse. Only in New Jersey could the capture thesis be validated, and then only in the period between 1987 and 1992. The notion that elected and public officials play second fiddle to the agendas of the interest groups is flatly rejected by the evidence; and the hypothesis that shifts in campaign donations led to support for deregulation is rejected because of the lack of any confirmatory evidence. The only hypothesis that is supported addresses shifts in the

configuration of interest group support prior to deregulation. It should be noted, however, that those shifts were consistently less pronounced than the shifts in support by key policy makers.

Table 7.1: Theory of Economic Regulation Hypotheses and Results

	MD	MA	NJ	NY	Overall
E1: Rate Setting should benefit hospitals more than consumers.	NO	MIXED	YES	MIXED	MIXED
E2. Shifts in the configuration of interest groups supporting rate setting should accompany deregulation.	-	YES	YES	YES	YES
E3. Shifts in interest group support should not be observable in Maryland.	MIXED	-	-	-	MIXED
E4. Elected officials should play only a secondary role, with interest groups leading the agenda.	NO	NO	NO	NO	NO
E5. Identifiable shifts in overt political support from interest groups to key legislative leaders should be identifiable.	NO	NO	NO	NO	NO

Table 7.2: Punctuated Equilibrium Model Hypotheses and Results

	MD	MA	NJ	NY	Overall
P1. An identifiable "policy idea" should accompany deregulation.	-	YES	YES	YES	YES
P2. In Maryland, we should not observe the emergence of the new policy idea, or else have clear indications of non-acceptance.	YES	-	-	-	YES
P3. In deregulated states, we should observe altered institutional structures to account for the demise of the old idea and the ascension of the new one.	-	YES	YES	MIXED	YES
P4. In Maryland, we should observe no similar institutional change.	YES	-	-	-	YES
P5. In deregulated states, we should observe the emergence of new players who, by broadening the scope of conflict, undermined the rate setting policy monopoly.	-	YES	YES	YES	YES
P6. In Maryland, we should observe either no such new players, or clear indications as to their ineffectiveness.	YES	-	-	-	YES

Ultimately, the theory of economic regulation is rejected because it represents too deterministic a model, too formulaic a construct, in the face of the volatile and fluid political context in each state. The ground of interest group influence and conflict is rich in the world of state health sector regulation. But the rigid formulations of the theory of economic regulation seem to freeze more than loosen the soil for helpful examination. The search for the elusive and powerful "cartel" that directs the activities of legislators, executives and regulators is not successful because there are too many contestants in this field for one player to be able to determine all of the outcomes. It is too rigid to suggest that the producers must always win out over the consumers: sometimes consumers do win, even if by accident! It is not realistic to suggest that public officials are simply ciphers in search of favors and campaign dollars from the wealthiest interests. We come back to Wilson's comments in relation to Niskanen's rigid bureaucratic formulations: "The truth is more complicated." [5]

By contrast, the hypotheses of the punctuated equilibrium model of policy development are strongly supported by the evidence. We can discern clearly that a "policy idea" undergirded the rate setting structures developed in the subject states in the 1960s, 1970s, and 1980s. We can also observe the development over the course of the 1980s of a replacement "policy idea" that toppled rate setting's hegemony. Recognition of and support for the new idea developed slowly, gained momentum -- often at a rapid rate, as in New Jersey in the summer of 1992 -- and definitively replaced what had come before. Except in Maryland, policy makers in the other three states found themselves periodically evaluating and reshaping the contours of their regulatory model, most especially in Massachusetts and New York where regular sunsets were built into each new rate setting model. There were plenty of opportunities between the late 1970s and the 1990s to get rid of rate setting. Policy makers weren't willing or able to do that until a replacement idea reached maturation. When it did, they moved.

As the punctuated equilibrium model suggests, we can clearly identify policy monopolies in each state, differing in shape and effectiveness, that maintained and defended the rate setting idea throughout its history and evolution. As the replacement policy idea gained momentum, we can observe in the subject states alterations in the makeup of the policy monopoly -- both through the addition of new participants and through changed positions of some central players. What is most clear, however, is that policy ideas support and legitimize the policy monopolies, and replacement ideas lead to the monopoly's destruction.

Finally, we can also observe the alteration of the institutional landscape as a result of deregulation and the ascendance of the new policy monopoly. In each state, some institutions and structures disappear and others form to reflect the passing of one regulatory form for another. Consistently, each new structure reflects an aspect of the new prevailing policy idea.

Overall, the punctuated equilibrium model presents a flexible but definable pattern of behavior in regulatory systems: regulatory schemes are born out of explosive crises when old ideas no longer work, and the status quo no longer meets current needs; after a period of seeming stability and equilibrium as the new idea evolves, the new system inevitably confronts a new crisis leading to a new replacement policy idea and structure. At both the broad and minute levels, this model fits well the development and disposition of rate setting in the subject states. It is a model well worth investigation and testing on other regulatory and policy structures.

Conclusions: Interests and Ideas in Health Policy

While not consistently true, it was generally the case among the 60 interviewees that interest group subjects viewed interests as a more powerful influence on policy than

ideas, while policy makers viewed ideas as the more important dynamic. (Because this study was developed, undertaken, and written by a policy maker, readers should beware.) This finding should not be surprising. Leaders of interest groups represent distinct and compelling sets of requirements that demand constant attention. Interest group representatives must satisfy their own boards and constituencies or face speedy dismissal. At one level, the groups speak for the ideals and the world-view of their respective industries, but at another level, they simply represent trades seeking their optimal place in and share of the market. Dollars-and-cents considerations play very powerfully in their operations and agenda setting. Ideas and other abstractions seem too often a desired luxury rather than a daily imperative.

Public policy makers must listen to interest group concerns carefully or face their own potential dismissals. But policy makers' constituencies are more diverse and dispersed; the fine details of regulatory subsystems miss the attention spans of most voters, and like it or not, the interest groups always have to come back for more. Even with the deregulation of rate setting, all of the interest groups in the subject states that were former members of the policy monopolies are still at their respective state capitals, pushing agendas, making deals, and looking for favored treatment in whatever the health system issue of the day happens to be.

Though it would surely be considered an heretical notion by Stigler, Feldstein or any of the other economic regulation theorists, there is a higher purpose than interest group agendas that attracts and holds many, though not all, policy makers and interest group leaders to the policy process. Ideas matter and cannot be dismissed. They have a distinct life of their own, and force both interest groups and policy makers to follow along, frequently against their wills. Like it or not, policy makers and interest groups at the state and federal levels are reacting to the market place of ideas that have developed overwhelming momentum in the current culture. Just as clearly, however, these prevailing ideas will change and will be replaced by other notions and ideas that will force an entirely

different set of reactions and responses by the same and future policy makers and interest group leaders.

Consistent with the punctuated equilibrium model, we can observe that ideas are more in play at some times than others. When policy monopolies are in the seeming "equilibrium" stage, and the prevailing policy idea is not under challenge, the battle of ideas takes a back seat and interest group politics prevail -- who gets what, when, how and why, in Laswell's formulation. [6] But the time inevitably arises when interest groups take a back seat to the battle of ideas, when the fate of the current policy idea is very much at question, and when the shape of the replacement policy idea is still not fully formed. It's the political process itself that gives the new idea its most recognizable shape and appearance. That process is extraordinarily tough, often merciless, and leaves many potential and promising ideas stranded by the wayside. The process doesn't guarantee that the "best" ideas survive, only the most durable, and only the ones that have the best "fit" with the culture and climate of the times.

Implicit in the rejection of the theory of economic regulation is a parallel rejection of rational choice theory as a universal explainer of human behavior. Morality, solidarity, patriotism, love, hate, jealousy, and a wide array of irrational behaviors have a share in shaping what happens in all of our lives, not the least in our public lives. Self interest is not rejected by this critique. Oftentimes it is dominant. It is foolish to leave self interest unexamined when any political behavior comes into question. But it is equally implausible to suggest, as too many rational choice theorists attempt, that nearly every aspect of life and public policy can be explained through analysis of self interest.

We conclude by affirming the importance of dual motivation in the analysis of public policy and public affairs. Rational choice and public interest can both be found in most politicized situations in different measures. Interests count, and so do ideas in the construction and deconstruction of policy.

Notes to Chapter VII

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APPENDICES

APPENDIX A**INTERVIEW SUBJECTS****Maryland**

(Positions listed are current as of June, 1995)

Dr. Gerard Anderson, Professor, Johns Hopkins School of Public Health

Livio Broccolino, Chief Legal Officer, Blue Cross and Blue Shield of Maryland

Miles Cole, Director of Business Affairs, Maryland Chamber of Commerce

Ernie Crofoot, former member of Health Services Cost Review Commission; AFL-CIO

Geni Dunnells, Executive Director, Maryland Association of HMOs

Eugene Feinblatt, Attorney, Chairman of Maryland Commission on Health Care Financing

Thomas Goddard, Director of Legislative & Regulatory Affairs, New York Life Health

Plus

Paula Hollinger, State Senator, Chair, Joint Committee on Health Care Delivery &
Finance

Robert Kowal, Chief Executive Officer, Greater Baltimore Medical Center

Larry Lawrence, Executive Vice President, Maryland Hospital Association

Robert Murray, Executive Director, Maryland Health Services Cost Review Commission

Deborah Rivkin, Executive Director, League of Life and Health Insurers of Maryland

Jerry Schmith, Deputy Director, Maryland Health Services Cost Review Commission

Casper Taylor, Speaker, Maryland House of Delegates

Dr. Martin Wasserman, Commissioner, Maryland Department of Health and Mental
Hygiene

Massachusetts

(Positions identified are those held during 1991)

Charles Baker, Massachusetts Undersecretary of Health and Human Services
 Bruce Bullen, Commissioner, Massachusetts Division of Medical Assistance
 Carmen Buell, Representative, Chair, Joint Committee on Health Care
 Edward Burke, Senator, Chair, Joint Committee on Health Care
 William Carroll, President, Life Insurance Association of Massachusetts
 Thomas Finneran, Representative, Chair, House Comm. on Ways and Means
 Paula Griswold, Chairperson, Massachusetts Rate Setting Commission
 Stephen Hegarty, President, Massachusetts Hospital Association
 Robert Hughes, Executive Director, Massachusetts Association of HMOs
 Richard Knox, Medical Editor, The Boston Globe
 Judith Kurland, Chief Executive Officer, Boston City Hospital
 Richard Lord, Director of Research, Associated Industries of Massachusetts
 Robert Restuccia, Executive Director, Health Care for All
 Elizabeth Rothberg, Director of Issues Management, Life Insurance Association of
 Massachusetts
 Steven Tringale, Vice President for External Affairs, Blue Cross of Massachusetts
 Celia Wcislo, President, Service Employees Local Union 285

New Jersey

(Positions identified are those held during 1992)

Dana Benbow, Vice President, Prudential Insurance Company
 Murray Bevan, Vice President for Government Relations, New Jersey Hospital
 Association

Joel Cantor, Director of Evaluation Research, Robert Wood Johnson Foundation
 Richard Codey, Senator, former Health Committee Chairman
 Pamela Dickson, Assistant Commissioner, New Jersey Department of Health
 Al Evanoff, New Jersey United Senior Alliance
 Dale Florio, Legislative and Regulatory Counsel, New Jersey HMO Association
 James Florio, Governor
 Charles Haytaian, Speaker, New Jersey Assembly
 George Laufenberg, Administrator, New Jersey Carpenters Fund; Rate Setting member
 Maureen Lopes, Senior Vice President for Health Affairs, New Jersey Business &
 Industry Council
 Charles Marciante, President, New Jersey AFL-CIO
 Dennis Marco, Vice President, Blue Cross & Blue Shield of New Jersey
 Thomas Terrill, Executive Vice President, University Health Systems of New Jersey
 Victoria Wicks, Chief Executive Officer, Health Insurance Plan of New Jersey

New York

(Positions listed are current as of July, 1995)

Debbie Bell, Coordinator of Policy Development, District Council 37, AFSCME
 Gerry Billings, Executive Director, State Communities Aid Association
 Robin Frank, Senior Program Advisor for Health, Governor's Office
 Richard Gottfried, Assemblyman, Chairman, Health Committee
 Kemp Hannon, Senator, Chairman, Health Committee
 Harold Iselin, Counsel, New York HMO Conference
 Richard Kirsch, Executive Director, New York Citizen Action
 David Oakley, Counsel, New York State Conference of Blue Cross & Blue Shield Plans
 Kenneth Raske, President, Greater New York Health Care Association
 Ed Reinfurt, Vice President, Business Council of New York State

John Rodat, Consultant

Dr. John Rossman, Vice President for Economics & Policy Development, Hospital Assn.
of New York State

Diane Stuto, Vice President, Life Insurance Council of New York State

Ray Sweeney, Executive Vice President, Healthcare Association of New York State;
former Director of New York Office of Health Systems Management

James Tallon, President, United Hospital Fund of New York, former State Assembly
Majority Leader

Mark Van Guysling, Assistant Deputy Director of Health Care Financing, New York
Department of Health

APPENDIX B**INTERVIEW INSTRUMENT****Maryland and New York****A. Current Support for Hospital Rate Setting:**

1. Why do policy makers in your state continue the hospital rate setting system?
2. What have been the key events in the evolution of rate setting in recent years?
3. What are the key governmental institutions involved in the continuance of the rate setting system?
4. What is your perception of how well or poorly the rate setting law works today?
Key indicators of success or failure?

B. The Role of Interests

1. Are the following groups -- in general -- winners or losers because of the existence of hospital rate setting in your state?
 - hospitals
 - commercial insurers
 - Blue Cross
 - managed care interests/HMOs
 - consumers
 - business
 - labor
2. Who are the key individuals in the state who are most identified with support for the continuation of rate setting?
3. Is there pressure in your state to deregulate the rate setting system? If yes, how strong is the pressure, and do you see any changes in support for this position?
4. Are there any key individuals or groups whom you can identify as key advocates for deregulation? If so, are these new or long-standing positions in support of deregulation?

5. Are government officials active moves in decisions about the hospital rate setting law or more passive responders to the agendas and needs of various stakeholders/interests?

6. Of the groups interested in health policy, which are the key in providing political support to legislative and statewide candidates for office? Have there been changes in degrees of support in recent years?

C. The Role of Ideas:

1. Can you identify the policy "idea" behind hospital rate setting in your state?
2. Is there an alternative policy idea current today that could replace it?
3. Are discussions about hospital rate setting more about interest group agendas or policy ideas?

Massachusetts and New Jersey

A. The Deregulation Decision

1. Why did policy makers in your state decide to deregulate the hospital rate setting system?
2. What were the key events that led to the deregulation process? Key events?
3. Did any government institutions disintegrate, form, or significantly change because of the deregulation decision?
4. What was your perception of the operation of the rate setting law? How well did it work?

B. The Role of Interests

1. Was implementation of the rate setting law favorable or hostile to the following interests:
 - hospitals
 - commercial insurance
 - Blue Cross
 - managed care/HMOs
 - consumers
 - business
 - labor

2. Which groups or individuals were most prominent in advocating deregulation? Did this represent a change in their historic position?

3. Which groups or individuals were most prominent in opposing deregulation? Did this represent a change or a continuation in their historic position?

4. Were government officials active movers in the deregulation decision, or were they more passive responders to the demands of the affected interests?

5. Of the above mentioned interest groups, which are most prominent in providing political support to legislators and statewide candidates? Have there been identifiable changes in the levels of support among these groups in the years leading up to deregulation?

C. The Role of Ideas

1. What was the policy "idea" behind hospital rate setting in your state? Who was most associated with the idea?

2. What is the prevailing "idea" behind hospital regulation in the deregulated system?

3. Was the discussion of a new "idea" a prominent feature of the deregulation debate? If so, how can it be demonstrated?

APPENDIX C

INTERVIEW RESULTS

Maryland Interview Results (1)					
	Gerard Anderson	Livie Breccellone, BC	Miles Cole, CoC	Ernie Crofoot, AFL	Geat Dunnells, HMO
1. Why regulation?	hospitals and govt. see benefit to reg. as opposed to comp (RS and Medicaid)	effective way to provide UC; SAAC—substantial, affordable, available coverage	1. appears to keep costs below national average; 2. Md. has unique hospital structure	good hospital care at reasonable rates, and total equal access; quality and efficiency	1. sig. loss in fed funds if we dereg (in Congress, we're sort of looked on as an anachronism)
2. Key events	response to managed care and capitation	1. increased reporting on the differential; 2. special arrangements	1. formation of hospital networks; 2. new cost driven environment	stable	1. alternative rates
3. Key institutions	1. governor; 2. speaker; 3. HSCRC	1. HSCRC; 2. HCAC; 3. insurance commissioner	1. HSCRC; 2. planning commission; 3. insurance division	HSCRC	1. HSCRC; 2. HCAC; 3. planning
4. Dereg. advocates	some from managed care	HMOs such as US Healthcare and Health Plus	1. Jeff Emerson	1. Jeff Emerson 2. some CoC guys 3. Champ McCullough	1. Jeff Emerson; 2. CoC looking; 3. "our plans want to be satisfied w/ results first"
5. Dereg opponents	hospitals first, second and third	hospitals	1. hospitals (we've got members on all sides)	1. unions and management; 2. providers; 3. HMOs	1. regulators; 2. hospitals; 3. politicians
6. Govt. active or passive	"almost non-participants, it's a non issue"	most are passive	mostly passive	active: Taylor and Hollinger	passive
7. Key political players	NA	1. medical society; 2. blue cross; 3. HMOs as X factor	1. hospitals; 2. labor; 3. business	1. doctors; 2. unions	1. hospitals; 2. business
8. RS Idea	mech. to control price of services and rate of increase	equitably accommodate UC, esp. for inner city hospitals	to prevent cost shifting among payers	we had to get a handle on costs, and it has moved to efficiency and quality	poor people should be treated the same
9. Dereg Idea	same old debate—market or payment system	let the market go where it will	markets would be most efficient sorter; "we're clouded because of the wolver"	free market system	other ways to tax for UC; and fewer people are in the hospital
10. Ideas vs. interests in outcome	NA	interests "if there's any fire to this debate, it's fueled by self interest"	"isn't policy always about interest group agendas?"	NA	interest group
11. RS winners & losers	hospitals—winners comm. ins—winners BC—winners HMOs—losers consumers—winners but not that strong bus—winners labor—losers	hospitals—winners comm. ins—losers BC—winner HMOs—losers consumers—winner business—mixed labor—losers	hospitals—winners comm. ins—winners BC—winner HMOs—losers consumer—winner business—mixed labor—winner	hospital—winners comm. ins—winners BC—winners HMOs—winners comm—winners business—unclear labor—winner	hospitals—winners comm. ins—losers BC—losers HMOs—losers consumers—both/neither business—losers labor—losers
EXTRA	waiver is "absolutely critical"	deep division within BC; "the waiver is critical to the system"	"one of the primary reasons to protect the system. I've often wondered why someone who reads the Wash Post doesn't question it?"	"if we were to lose the waiver, we would lose the reg. system"	"if you lost the waiver, the reason for the reg. system would cease to exist"

Maryland Interview Results (2)					
	Eugene Fehnbalt	Thos. Goddard, NYL	Sen. Paula Hollinger	Rob. Kowal, GEMC	Rbt. Murray, HSCRC
1. Why regulation?	1. seen its benefits; 2. equity, fairness, avoiding of cost shifting 3. dirty secret 'drafted by MHA'	afraid of consequences: large # of hospitals would shut down; MHA political clout	successful: if it ain't broke, don't fix it; no hospital dumping	they are used to it and it provides jobs for legislators	1. fair system provides access; 2. equity lacking in other states 3. local solutions 4. flexible system
2. Key events	Methodologies have changed to adapt to competition	current hospital squeeze—laying groundwork for broader system; 'reticence in the realm of public opinion regarding RS'	growth of managed care: there's a war going on	incremental experimentation, tinkering, reactionary	1. major method changes in guar inpatient rev system, vol. adjustments, UC, 2. alternative RS methods experiments 3. capitation
3. Key Institutions	HSCRC	HSCRC, HCAC	HSCRC—truly expert at what they do; there's a lot of trust that policy makers have put into that commission	HSCRC—attitude in Ann is that motherhood apple pie and rate setting all go in the same boat	5 entities: HSCRC, HBPC, Insurance, Coll, HCAC
4. Dereg. advocates	HMOs and other insurers	Jeff Emerson, no one else openly—many would love to get rid of it: "we all contract with the state"	Jeff Emerson; HMO Assn. moving that way	1. business payers— Black & Decker, Marriott; 2. HMOs; 3. some hospitals	1. Jeff Emerson; 2. Ray Brunka from Black & Decker; 3. a lot behind the scenes
5. Dereg opponents	MHA and trustees; legislature	hospital assn.; the speaker	MHA; advocate groups; local governments	the commissions and the bureaucrats; the legislature; MHA that has pushed, created, babied it and feel it's their thing	1. Frise & labor; 2. Don Hillier, 3. business leader, 4. MHA; 5. Speaker; 6. Hollinger 7. and key legislators
6. Govt. active or passive	active	passive: the issues are too complex	very proactive	passively respond to the pressure	they respond passively
7. Key political players	hospitals	doctors; hospitals	chamber, HMOs	NA	MHA, physicians
8. RS Idea	avoid being regulated by out of state agency; cost control and system fairness	fed DRGs are bad and we can try something else	reward hospitals for keeping costs down	reaction to cost plus system; government sponsored cost shifting	market for health care is a case of market failure; RS is attempt to correct failure
9. Dereg Idea	let market forces govern; "there's no imp. political voice that wants dereg to happen"	"the free market as a countervailing idea"	the free market	tax to pay for indigent care	make consumers good purchasers, use the market and price sensitivity
10. Ideas vs. interests in outcome	both	interest groups	ideas matter	hard to tease out the two	interests and ideas
11. RS winners & losers	hospitals—winners comm. ins—neutral BC—losers HMOs—mixed consumers—winners business—neutral labor—big winner	hospitals—losers comm. ins—losing BC—losers HMOs—losers consumers—losers bus—losers labor—losers	hospitals—winners comm. ins—losers BC—winner HMOs—mixed consumers—winners bus—losers labor—winners	hospital—winners now comm. ins—losers BC—losers HMOs—losers consumers—losers bus—losers labor—don't know	hospital—winners comm. ins—winners BC—winners HMOs—winners consumers—winners business—winners labor—winners
EXTRA	very important—putting all payers on the same basis		It's critical—most people in the legislature don't give a damn	critical—if lost, the system would have to be drastically changed	crucial, vital, the cornerstone of the system—Scheffer Admin. said value of waiver was as much as a triple A bond rating

Maryland Interview Results (3)					
	L. Lawrence, MHA	Deb. Rivkin, LLHIM	Speaker Casper Taylor	Dr. M. Wasserman	
1. Why regulation?	1. effective in controlling costs, 2. equity and fairness	1. keep costs in control, 2. cover DC. "It's the sacred cow of Maryland"	model reg. system for the country - hospital rates well below national average	1. Medicare waiver; 2. indigent care 3. hospital assn. of trustees	
2. Key events	alternative rate methodology, from 10 to 2 yr. horizon for change; natural evolution	stable: 1. competition from surgi centers; 2. development of alliances and capitated deals; 3. managed care has become rampant	no adjustments in the last 5 yr.;	1. memo of agreement on collaboration; 2. distribute GME costs among all payers 3. distributed social costs	
3. Key Institutions	HSCRC, HPC, HSCAC, Inc, DoH&MH, Licensure, Medicaid	HSCRC/HRPC	3 commissions	HSCRC, HCAC	
4. Dereg. advocates	Jeff Emerson; HMO and CoC looking for examination	Jeff Emerson; HMO moving, will do so before us	CoC raising a flag, asking for changes	HMOs	
5. Dereg opponents	1. Assembly, 2. HSCRC, 3. labor, 4. some business, 5. MHA, 6. Hillar, 7. Blue Cross	MHA; legislators; Congress. Cardin.	3 commissioners; MHA; business would split; strong public support	hospitals, medical society	
6. Govt. active or passive	active-biggest dereg opponent would be GA	very strong and active	very active—we continue to drive the bus	I'm very active	
7. Key political players	1. business; 2. labor; 3. medical society	1. MHA; 2. Med. Chi; 3. Blue; 4. HMO is coming	1. hospitals; 2. docs; 3. HMOs, 4. business	NA	
8. RS Idea	reasonable rates, equity in the system, accountability	control costs and insure that all get hospital care, and no cost shifting	financial equity and quality of care	cost control, quality, access	
9. Dereg Idea	competitive marketplace	market co-competition and negotiated deals	free market system, "but I have grave reservations that delivery of health care lends itself to a free market"	same services for less and profit maximization	
10. Ideas vs. interests in outcome	ideas—public's entitlement to reasonable rates	Legislature can claim it's about ideas	this is about ideas - we fought interest groups to get it.	public's interests	
11. RS winner & losers	hospitals—winners comm. ins—winners BC—winners HMOs—winners consumers—winners business—winners labor—winners	hospital—winners comm. ins—mixed BC—mixed HMOs—losers consumers—losers business—losers labor—losers	hospitals—winners comm. ins—insure BC—winners HMOs—neither consumers—winners business—winners labor—winners	hospitals—winners comm. ins—winners BC—both HMOs—unclear consumers—winners business—winners labor—winner	
EXTRA	it is essential	that's what's keeping the whole system afloat - when we seem someone else paying the freight, that's why you haven't seen more people calling for dereg.—the waiver, that's the glue	very important, if lost, the system would start to disintegrate	if you take away the waiver, you cut Medicaid by a billion and a half, and you may dereg everything - if you have dereg of a \$5B industry, then it's like road kill, everyone's in here plucking this piece or that	

Massachusetts Interview Results (1)					
	Rick Lord	Rob Restuccia	Bob Hughes	Ed Burke	Steve Tringale
1. Why deregulation?	1. WW/CB believers in market forces	1. push from hospitals & business	1. it cost too much \$; 2. political-it manipulation; 3. bus lost faith	1. already dereg; 2. incomprehensible statutes; 3. purchasers no longer needed; 4. reg. weary; 5. hospitals message	1. managed care penetration, change in fin. equilibrium; 2. low value of BC discount and shadow pricing; 3. strong hospitals felt reg. hurts deals
2. Key events	1. Spring meetings; 2. lack of formal commission recommendations	1. collapse from business; when they decided no political will for reg., it was over.	1. weld election; 2. Finneran-an elevation; 3. c23 DMS creation->insurance reform	1. BC hemorrhage; 2. howlrm decision	1. evolution of managed care; 2. new administration; 3. Charlie Baker from congressman to directive approach
3. Govt. changes	1. Sign. drop in RSC authority	1. RSC no function; 2. Medicaid move to DMA, clear of RS	limits on Adm. agencies DMS BD & RSC	1. RSC lost; 2. Medicaid waiver & MHMA carve out	1. RSC became data repository; 2. emergence of Medicaid & political driven by purchasing agency
4. Dereg. advocates	1. Baker; 2. HMOs; 3. Blue Cross	1. teaching hospitals; 2. weld administration	1. MA/HMO; 2. MHA; 3. BC; 4. business; 5. teaching hospitals	1. weld Adm.; 2. HMO	1. BC, bolder of rate discount; 2. MA/HMO; 3. admin.
5. Dereg opponents	1. HCFA; 2. AFL-CIO	1. consumers; 2. labor; 3. some business; 4. BCH & public	1. HCFA; 2. academia (eager, Gordon, Roberts)	1. bob Buell	1. HCFA
6. Govt. active or passive	Active: CB & TF	Active -Weld, Leg passive	Passive: respond to political reality of no \$	Passive; business doubts; HMO people	Active: Burke, baker, Buell, McD, Dol
7. Key political players	1. hospitals; 2. labor	1. hospitals; 2. BC; 3. labor	1. MHA; 2. labor	1. hospitals; 2. insurance	1. hospitals; 2. BC; 3. bus; 4. labor
8. RS Idea	Govt. in-intervention needed to control costs; hospitals important to communities	Level playing field between insurers; public utility model/mkt forces weren't working	equity into system; UC pool as biggest indicator; access; commonality among payers	cost shifting-- shouldn't be big difference. between payers	75: Medicaid driven, need to cap all costs; 82 cost shifting
9. Dereg Idea	Costs not controlled, system un-successful; allow group purchasers to negotiate	mkt. forces would be more efficient, (begun in RS); inability of state to control hospitals	biggest barrier to access is affordability-- looking for price moderation	every payer for itself	central economic planning fell out of favor; mkt. forces
10. Ideas vs. interests in outcome		Ideas: evolution of ideas; dueling memos; ideas more in press than internal	Interests: inside game; unraveling as more saw RS as hurting them	Ideas: change in nature of payment for services	both, function of time & place
11. RS winners & losers	w: hospitals; l: ci, BC, HMO, cons, bus, labor	w: ci; HMO, cons, bus, labor. l: BC	w: ci, HMOs, labor, hospital (mix); l: business, BC	w: hospitals, HMOs, consumers, bus, labor; l: ci, BC	w: ci, labor; l: BC, HMO, bus; split: hospitals, cons

Massachusetts Interview Results (2)

	Steve Hegarty	Paula Griewald	Charlie Baker	Carmen Buell	Wm. Carroll, Lk. Rothberg
1. Why deregulation?	1. managed care penetration; 2. contracting as national idea; 3. hospital over-capacity	1. reg. system not fair or effective; 10 yr. never adjusted	1. hard to gauge true hospitals & because of retro settlements; 2. admin. committed to market & Medicaid managed care; 3. willingness to try something new; 4. TF & Charlie Baker	1. confrontational reg. system hadn't produced results, more gut than analytical; 2. new admin. hell-bent on different direction; 3. some hospitals thought they could do better	1. new admin.; 2. hospital dissatisfaction; 3. BC desire to get out of managed care
2. Key events	1. new Adm.; 2. summer bd. retreat	1. elec. of Repub. + sunset; 2. hv&km going further	1. weld election + veto proof senate; 2. Gov. decision right after election to not delay; 3. mgt. w/ hospitals	1. election; 2. accumulation of inf. and discussion	1. summer and fall Calif. lit got around; 2. health care hearing w/ Charlie Baker, MHA, BC, bus
3. Govt. changes	very little: Medicaid vs. RSC	1. RSC closing down reg.; 2. DPH status impact; 3. DMS-UC pool as \$ for uninsured	1. Medicaid allowed to contract; 2. RS into inf. business	1. RSC from reg. to inf.; 2. HOSPAC as monitor; 3. Del lost clout to EOHHS	1. RSC lost power; 2. ascendancy of baker's office; 3. Del lost authority
4. Dereg. advocates	1. MAHMO; 2. BC	1. baker for Gov.; 2. MHA members	1. Gov.; 2. Ed Burke & Charlie Baker; 3. HMOs, 4. BC, 5. hospitals; 6. Finerman	1. business; 2. Charlie Baker; 3. hospitals CFOs; 4. labor Taft h trusts; 5. Joe Trainor	1. HMOs, 2. baker; 3. BC
5. Dereg. opponents	1. HCFA; 2. some business	1. HCFA, consumer groups; 2. some hospitals	1. McD, 2. other leg. 3. HCFA	1. McD 2. HCFA 3. sager 4. Knox	1. HCFA; 2. LIAM
6. Govt. active or passive	active: Charlie Baker pushing contracting	active: baker, C. Buell, rest of leg more reactive		active: baker, T. Finerman, Trainor very involved	active: baker moving; legislature more studying mode
7. Key political players	1. insurers; 2. HMOs, 3. hospitals	1. hospitals	1. hospital; 2. ci/BC; 3. bus/lab	1. ci; 2. BC; 3. hospital 4. labor	1. hospitals; 2. labor; 3. business
8. RS Idea	cost containment, prospective, govt. need to do something	mkt. didn't work; utility model because of mkt. failure	everyone should pay the same for same volume; cost containment	fair and equitable price for services, all payer, access, planning	health care didn't operate as free mkt., needed intervention
9. Dereg Idea	frustration w/ RS; acceptance of market forces	mkt. forces can and do work w/ managed care participation.	best way for efficiency is to stop paying cost and start paying based on prevailing market;	mkt. forces in overcapitalized environment would make better decisions in leveling out. Strong and smart purchasers	managed care could do the same thing; reward success, and punish unsuccessful
10. Ideas vs. interests in outcome	interests: forces building & pulling	both: theory would not prevail on its own; big players wanted	both: ideas valuable, but need to fit into interest group framework or else no go	ideas: lot of education, time to try something new	both: always seems to be interest group, but remarkable turnaround
11. RS winners & losers	w. HMO, bus, labor; l. BC; mix: hospital, cons.	w. hospital, ci, cons. bus, labor; l. BC, HMO			w. ci, consumers, labor; l. BC, bus; m. hospital

Massachusetts Interview Results (3)					
	Bruce Bullen	Judith Kurland	Richard Knox	Celia White	Tom Ellerman
1. Why deregulation?	1. interest of payers as changes became irrelevant; 2. control cost shift 3. for Medicaid, Payment on Account Factor manipulation	1. pressure from hospitals; 2. competition thing; 3. worn down by inability to defend	1. weariness, inevitability, easier to be ideology than work things through; 2. duke approach discredited; 3. lack of opposition	1. desire for selective contracting by hospital & insurers and less reg.; precursor to capitation	1. Dereg market would be more coherent; 2. RSC was inequitable, not factual, and sometimes political
2. Key events	1. weld admin. bc. belief in mkt; 2. experience of C23; 3. baker's performance	1. late '80s hospital decision to dump Medicare waiver	1. election * fallout; 2. hearing was window	1. weld election; 2. national context	1. Carmen's embrace; 2. McGovern's decision
3. Govt. changes	1. emergence of Medicaid managed care 2. decline of RSC — hospitals not able to twist RSC dial any more	1. Medicaid stronger; 2. RSC weaker	1. dhp/don & RS	1. 1. RSC; 2. don less imp; 3. DMS retraining eliminated	1. allow Medicaid to set rates
4. Dereg. advocates	1. HMOs; 2. business; 3. Medicaid; 4. baker 5. bob Hughes	1. MHA/COBTH; 2. smaller hospitals; 3. insurers; 4. big business	1. baker; 2. hitech crowd	1. big business; 2. big hospitals; 3. big insurers; 4. weld/baker	We caught the industry by surprise: Weld, Baker, Carmen, Mc, McGovern
5. Dereg. opponents	1. HFA; 2. labor; 3. hospitals split	1. HCFA; 2. pub health people; 3. academics	1. McD; 2. sager	1. med; 2. HCFA	1. Med; 1. Med; 1. Med
6. Govt. active or passive	active; weld admin. view	passive	active: exec; leg was more passive	active: Buell moved	active movers
7. Key political players	1. hospitals, 2. labor	1. hospitals, 2. business	1. hospitals, 2. business, 3. BC	1. insurers, 2. business, 3. hospitals	business, labor, consumers
8. RS Idea	need honest broker betw state, providers & payers to get honest price, to prevent gouging	health care as reg. utility; fair return, reasonable price, access to services	only Gov. could countervail angst hospital money machine	set rates based on financial need and stab of institutions, social planning aspect	Market was not a real Adam Smith type market; consumers don't have real choice
9. Dereg Idea	no more need for brokers as 3rd party payers became large	private mkt. forces more effect; competition would bring down prices	mktplace would do better job	market could determine these things	Market driven system was worth the effort and could do at least as well
10. Ideas vs. interests in outcome	ideas: not pitched battle; not clear position	both: movement of ideology, but no clear exam of all ideas	both: not a lot of debate,	ideas: shift in political paradigm	battle of ideas — 1 struggled with this one inside, and I was not aware of anyone's interests on it outside.
11. RS winner & losers	w: labor; l: BC, HMO, bus; mic: hospitals, ci, consumer	w: hospitals, ci, BC, HMO; l: cons, bus, labor	w: ci, BC, HMO, com, bus, labor; mic: hospital	w: hospitals, ci, BC, cons, labor; losers: bus, HMO	w: don't know l: blue cross dk: hospitals

New Jersey Interview Results (1)

	Dana Benbow, Pru	Murray Bevan, NJHA	Joel Cantor, RWJF	Sen. Codey	Dickson, Daif
1. Why deregulation?	1. charge stories; 2. lost pizzazz as model of equity; 3. united voice; 4. once BC lost discount, we all wanted right to negotiate	1. pull out of Medicare in late 80s; 2. growing HMO penetration; 3. growth of UCTE—unacceptable cost shift/	1. anti-reg. sense in Legislature; 2. no opposition from Gov.; 3. system not performing well in recent years; 4. lousy press. 5. rise in UC	1. Way to save \$ to fully fund UC; a cover for them not to have to spend the same amount of \$ on UC	1. cost shift lead — Medicaid, UC, wrong incentives 2. payers wanted to control their own costs—HMOs 3. public confident, lost
2. Key events	1. "the minute the Wolin decision came down";	1. Wolin's decision; 2. Gov.'s decision not to fight to hold on.	NA	Republican takeover; "the system was going to change dram if we stayed in power"	Gov. said we have to change the whole system — can't recall turning point
3. Govt. changes	1. price setting eliminated; 2. created Easen HSCComm.	1. atrophy of RS w/in DoH; 2. redistribute of UC from need to poll calculation.	1. new commissions; 2. DoH functions	1. Easen HSC which is now being disbanded	1. RS abolition; 2. creation of 3 new boards 3. loss of DoH power
4. Dereg. advocates	1. Brenda Bacon /DoH; 2. health reform coalition; 3. hospitals	1. Labor/Laufenberg; 2. Bruce Coe from B&I 2. Brenda Bacon	NA	1. legislature Repub. 2. bus.&ind. assn. 3. commercial ins.	1. Florio admin.; 2. legislature leaders 3. NIB&IA
5. Dereg opponents	Cathedral Health Care systems and urban hospitals	1. Harvey Holzburg from RWI Hospital; 2. Kevin Haldern; 3. Sr. Jane Brady	1. urban hospitals	1. urban hospitals "everyone agreed that the system was a not working"	1. urban and teaching hospitals
6. Govt. active or passive	equal partners; "they believed they were reforming the overall system and making things better: they could have held on to reg. if they wanted"	"Some in Leg were active; Florio not sure what to do and more passive"	Legislature was active because of anti-reg. Gov. office and DoH were passive	mostly passive — none of the Repub. had built up great expertise	active
7. Key political players	1. providers: phys and hospitals; consumers and their groups: LWV, AARP; HMOs.	1. Hospitals and docs; 2. Business 3. Labor	NA	1. business 2. commercial ins. 3. hospitals	1. hospitals; 2. HMOs; 3. business
8. RS Idea	"it was an idea whose time had come and gone"; "they thought they were simplifying and rationalizing the system, because of the markiness of the prior payment mechanisms — also wanted to avoid two tiers of care."	initially, it was a way to deal with UC and better access and to control costs; crossover in '87 when we lost waiver and it started to become a problem	Incentive for cost control by bundling and fixing price per admission; later to distribute UC burden more fairly	to control the cost of health care — hospitals would get x dollars for each procedure, but the system got out of control	control costs and universalize access to care; at time, not good balance between payers and providers — govt. needed to provide balance.
9. Dereg Idea	"we were prepared to let the market work"	No policy idea — I couldn't come up with one...way to deal with ineff. incentives that were contrary to managed care.	competition was good and reg. prevented market from working; ideological	the market will work better and competition will drive down prices	free market could be better regulator than govt. when business and managed care participate
10. Ideas vs. interests in outcome	"this was mostly about interests. there were people in the ad who clearly used ideas. But the plain fact is that because of a legal decision, interests changed."	More about interests — allowed insurers to step to the fore.	agendas of lgs; secondarily about competition; who pays	ideas — universal opposition from Dem. and pockets of Repub. who represent semi-urban areas	ideas: a lot of people started to say too much govt., let free market run this thing.
11. RS winners & losers	hospital—winner; comm.—losers; BC—losers. MANAGED CARE—losers. consumers—mixed. business—losers. labor—losers.	hospital—winner comm.—losers BC—winners managed care—losers consumers—losers bus.—losers labor—losers	hospitals—mixed; winners; comm.—winners; BC—neutral; managed care—unclear; consumers—winners; business—losers labor—losers	hospitals—winners comm.—winners BC—winners managed care—winners consumers—mixed business—mixed labor—mixed	hospitals—winners comm.—winners BC—losers managed care—losers consumers—winners business—losers labor—winners

New Jersey Interview Results (2)					
	Al Evansoff	Dale Florio, NJHMO	Gov. Jim Florio	Charles Haytalan	Gov. Laufenberg
1. Why deregulation?	1. hospital lobbyists wanted no regs at all	1. true cost of hospital care not reflected in bills; 2. harming to less govt.	1. 19% surcharge 2. need for mkt. economic to get people private insurance.	"when we had an opportunity... we said DRG prog. has to go"	1. "we were not looking to triple DRG system, but to find fairer way to finance UC... RS dereg not my explicit desire... 2. pols weren't confident w/ system in place 3. when Medicare dropped out, problems began... 4. coal. position was for less reg., not total dereg."
2. Key events	no point in time	NJHA meeting of igs, came together in 2 mtg.	evolutionary-DRGs losing benefits	when Florio realized that he had to work w/us	"shared perception that in final years, RS was ineffective" Essen he comm.
3. Govt. changes	RS out of business	1. RS out of bus; 2. hospitals merging	1. financing UC; 2. subsidies health ins plan	essential he commission	
4. Dereg. advocates	1. hospitals; 2. insurance cos.	1. business & labor - Bruce Coe and c. Marciano	NA	1. Florio Adm.-BB 2. Sen. Pres.; 3. me "very rare instance where lobbyists were all left out of the room"	1. reform coalition 2. Brenda Bacon 3. Repub. leadership, Coler & Hook
5. Dereg. opponents	none that I recall	1. Tom Terrill; 2. some individual hospitals	1. urban hospitals "virtually nobody"	1. medical society; 2. AFL-CIO on UC	"no recall of any strong voice"
6. Govt. active or passive	passive	more passive, though not Governor	active	"we were active in setting agenda"	passive
7. Key political players	1. insurance cos. 2. hospitals	1. business 2. trial lawyers	small business; labor; HMOs; insurance	1. Labor for Dem.; 2. Med. groups for Repub.	business
8. RS Idea	guarantee care for the uninsured	price controls; "health services one step below public utilities"	need for constraints on ffs market	NJ as a pilot state	equitably charge one rate for specific procedures; fund charity care
9. Dereg. Idea	free competition theory	reg. system didn't work;	structured competition	we had to change the way the system was working.	let free enterprise motivate the system
10. Ideas vs. interests in outcome	interest groups	"inside the coalition" ideas took a front seat	"what was best idea for containing costs"	"very first issue on which both sides agreed to work together-that made all the difference, in the result"	"in the reform coal. most wanted to address the problems" but made difficult by political realities
11. RS winners & losers	hospital-winner comm. ins-unclear BC-winner HMOs-unclear consumers-winners bus-in-between labor-winners	hospital-winner comm. ins-lossers BC-lossers HMOs-in the middle consumers-winners bus-lossers labor-lossers	hospitals-multiple committed ins-winners BC-lossers HMOs-neutral consumers-lossers bus-lossers labor-unclear	hospital-winners comm. ins-NA BC-mixed bag	hospitals-winners comm. ins-winners BC-winner HMOs-winner consumer-loser business-loser labor-lossers

New Jersey Interview Results (3)

	Maureen Lopes, B&I	Chlo Marciano	Deanna Marco, BC	Tham Terrill, UHSNJ	Victoria Weeks, HIP
1. Why deregulation?	Paying too much for hospital care; wanted more competition	"it started to go crazy"	state policy people viewed as inefficient, wrong incentives; "DRG was like a methadone program - a guar bottom-tom line every year and no one could understand how it worked"	1. loss of Mdnr waiver 2. RS falling behind 5 years 3. size of surcharge and printing of bills	RS inhibited the spread of managed care which was the best way to hold down costs
2. Key events	1. reform coalition June 2. HA vote to support	velin case--the minute we were successful	1. velin ruling	NIHA ad hoc coalition	NA
3. Govt. changes	1. Easen ha comm; 2. RS sunset	1. RS comm. eliminated 2. eas HSC	1. RS eliminated 2. Easen HSC & other boards	elim of RSC	NA
4. Dereg. advocates	1. bus and labor 2. keep legislature staff - Coler & Hook	AFL-CIO	1. Brenda Bacon & Gov.'s office; 2. Sen. Lou Bassano, health dir; 3. Dr. Colburn; 4. Reps Haytain & Felice	1. Bruce Coe 2. Lou Scibetta 3. Charlie Marciano	NA
5. Dereg opponents	1. urban hospitals 2. could never tell about BB	tacit from doctors and hospitals	bureaucrats in RS comm.; Bruce wanted dereg	1. hospital alliance of sr. Jane 2. UHS, UM&D	NA
6. Govt. active or passive	"never had sense we would get shot down from government"	active	active	some passive and some active	NA
7. Key political players	1. hospitals 2. BC 3. labor	NA	1. BC, "we've still the 2000 lb gorilla; 2. providers 3. HIP, Pm, USHC	1. labor 2. business 3. insurance	NA
8. RS Idea	one rate and hospitals would have to manage	concept to stabilize the cost of health care	1. reimbursements should be all the same; "you did not have to be MBA to be hospital CFO because, every year the state would pony up the \$ to make you whole"	treating hospitals like utilities; insure payment for access	NA
9. Dereg Idea	market does better at controlling costs and rewarding efficiency -- we had 3 yr. transition	"we had people who could sit w/ hospital, people and argue rates"	competition would hold down costs	hospital had grown fat, lazy, ineffic, out of control, can't close -- let chips fall where they may	NA
10. Ideas vs. interests in outcome	ign "sorely does a big idea carry the day... Florio had a vision"	the key fight was affordable health care	ideas	conflict of ideologies	ideas and interests
11. RS winner & losers	hospitals--winners comm. ins--losers BC--losers HMOs--losers cons--winners to losers business--losers labor--losers	hospitals--winners BC--losers HMOs--not affected consumers--losers business--losers labor--losers	hospitals--winners comm. ins--losers BC--losers HMOs--NA consumer--losers bus--loser labor--loser	hospitals--winners comm. ins--losers BC--winners HMOs--losers consumers--winners bus--winners labor--winners	NA

New York Interview Results (1)					
	Debbie Bell, DC37	Gerry Billings	Robin Frank	Richard Gottfried	Sen. Kemp Hansen
1. Why regulation?	1. hospitals are major employers; 2. health unions are political, involved and heavy contributors; 3. so many teaching hospitals	1. accomplished early stabilizing purposes; 2. saved distressed hospitals; 3. hospitals' significant political leverage	system has evolved over time from I to V;	from ceiling to floor on costs — protest hospitals from suicidal rates — force payers to contribute to socially imp. activities	entwined pub political objective; no one knows what the successor should be.
2. Key events	not a lot; evolving; managed care in Medicaid is one; move away from hospital care. "serewing the light bulb in was the Pataki election, and flipping the switch came in public forums"	static until IV & V; mainframe for other health fin pieces — bells and whistles	Traveler's case; development of managed care; move from per diem to case payment;	88 to DRG, big upheaval; 90-93 big reimbursement increases; 90 child health plus;	dynamic, trend factors that take into acct. med. inflation; addition of public policy factors
3. Key institutions	Legislature and Governor	1. 2 health chairs; 2. Council on HC Financing; 3. Insurance Chair; 4. Gov. and Health Commissioner	Comm. of Health; Insurance Dept.; Social Services, Dept.; Medicaid	DoH Comm; Budget division; governor; legislative committees	1. Sen. chair of health; 2. assembly chair of health; 3. comm. of health;
4. Dereg. advocates	1. Pataki; 2. DuBois; 3. LT Gov.; 4. mco's	Gerry B; Business Council; LIC; BC; Tully; Can you feel the tectonic plate shifting?"	medical society; parts of labor	business; insurance	businesses & purchasers "why do you have these dinosaurs?"
5. Dereg. opponents	1. advocates for uninsured; 2. hospitals but not strongly; "I don't think org. labor is going to stand up for it"	1. Hospital Assn, though a split;	interesting coalitions are forming among hospitals, business, and consumer groups	hospitals; legislature mixed; unions mixed	hospitals that get extra support, and municipal hospitals
6. Govt. active or passive	Generally, they have been active, but their positions have been motivated and informed by lgs — active	active	very active	passive—we look to various interest groups to find out what they want — we convert good ideas to legislative language	active
7. Key political players	1. labor; 2. hospitals; 3. HMOs;	1. hospitals;	NA	hospitals; business, insurance, HMOs;	NA
8. RS Idea	hospitals losing too much \$ and costs rising too fast; important goal was stability	control costs, financial stability, indirect way to control utilization	curtail cost shifting, use system to cover UC; capital issues	social control of health care resources	fix costs and make hospital care more affordable and stable
9. Dereg. Idea	free market/chaos	no common vision yet—competitive system with safety nets	negotiated rates	control by capital of health care resource	free competition
10. Ideas vs. interests in outcome	money — political makers and interest groups have learned to define their issues and coalesce where approp. to best serve their interests	always been about raw political negotiations...we haven't talked about ideas since orig NYPHRM...it may be starting	NA	interests	NA
11. RS winners & losers	hospitals—winners comm. ins.—losers BC—winners HMOs—mixed consumers—winners business—winners labor—winners	hospitals—winners comm. ins.—losers BC—losers HMOs—big winners consumers—losers business—losers labor—both	hospitals—mixed comm. ins.—losers BC—losers HMOs—consumers—losers business—labor	hospitals—winners comm. ins.—losers BC—mixed HMOs—mixed consumers—winners business—losers labor—winners/mixed	hospitals—now losers comm. ins.—no effect BC—losers HMOs—winners consumers—mixed business—mixed labor—mixed, losers
EXTRA	"hard to make adjustments as they were needed...orig reforms became the prisoner of the interest groups that benefited from it"	UC pools not really assuring access to indigent—pools simple a blank check		the key block pulled out has been the HMO neg. rate provision	"I have said there won't be a NYPHRM six—but there's a learning curve that we have all got to get through"

New York Interview Results (2)					
	Harold Iselin, HMO	Richard Kirsch, CA	Dave Oakley, BC	Ken Raske, GNYHA	Ed Reinhardt, BCNYS
1. Why regulation?	1. sought reduced LOS; 2. no price discrimination; 3. pay for UC plus others	stability to the hospitals; stable funds for UC; "and it's a habit"	things have a way of continuing on after they should have died	grounded in policy ideology of NY—structured cost shifting, redistribution of funds to distressed hospitals	effective cost control measure — position now changed. hospital certainty. "It's simply a dinosaur"
2. Key events	isolated enhancements; 1988 was not a real change in HMO policy	use of UC for social purposes; hospital funds for non-hospital purposes	very static; changes are political flourishes of no great sign.	not static; more sophisticated in each rendition;	very dynamic last 2 yr.; single DRG;
3. Key institutions	DoH;	legislature; Gov.; DoH	Sen. health comm.; assembly health care; council on hf;	Health & Insurance Comm.; Major Ldr & Speaker; DoH; withdrawal problems	Gov.; DoH Comm.; DSS; DoH;
4. Dereg. advocates	Bus Cncl; Comm. Ins; Blues; "We would exist just fine with the status quo, but we would not oppose dereg."	business; managed care industry; Pataki administration	BCBS; traveler's case got people thinking	business council; BC; commercials;	DeBueno, Pataki; business; payers; "this has all happened within the last six months"
5. Dereg opponents	"there may not be any defenders...consensus"; if anybody, the hospitals	hospital workers and labor; distressed hospitals; consumers	labor leaders; hospitals; politicians	Dennis rivers & 1199, and DC37; mixed emotions of our members	Gottfried, Grannis, Tully; City legislators; hospital workers; hospital Astar;
6. Govt. active or passive	extremely active	generally passive	active	more passive than active—look to groups for positions	activist tradition
7. Key political players	labor; hospitals; business council	hospitals; doctors; insurance; business	NA	hospitals; Dennis rivers in the assembly; business council in the senate	Dennis river, DC37; hospitals
8. RS Idea	hospital cost containment; equity among sectors	rate stability without rapid inflation; create peace within the health care arena	to control health care costs and to ensure financial viability of hospitals	cost containment; cross subsidies of poor; prospectivity	save certain hospitals; fixed price for hospital product; "by the end, we were just tracking med. inflation"
9. Dereg Idea	marketplace will be better force for cost containment	lowering of prices, leading to lower costs; market in best force to lower prices	more competitive model	need to find way to solve GME and capital needs	deep discounts, negotiate on basis of cost and quality;
10. Ideas vs. interests in outcome	this is a fight about money	interest group agendas;	was public policy issue that descended into politics	interests. up to now, largely ideology based. deep seeded believes in Cuomo Administration	this is about downsizing a system; interest groups affected, and income/earnings
11. RS winners & losers	hospitals—both comm. ins—losers BC—winner HMOs—winners consumers—losers business—losers labor—mixed	hospitals—winners comm. ins—losers BC—winners HMOs—winners consumers—winners business—losers labor—winners	hospitals—winners comm.—winners BC—losers HMOs—winners consumers—mixed labor—mixed	hospitals—mixed comm. ins—winners BC—losers now HMOs—big winners consumers—winners business—winners labor—winners—reg. and labor neg. go hand in glove	hospitals—winners comm. ins—losers BC—losers HMOs—winners consumers—losers business—losers labor—losers
EXTRA				waiver: Medicare was better payer than NY system. GME and DSH are the keys	

New York Interview Results (3)					
	John Reisman HANYS	Diane Stute, LACNYS	Ray Sweeney	Jlm Tallen, UHF	Mark VanGoyaling
1. Why regulation?	1. strong pre-regulation stance; 2. UC; 3. control on costs	expedience, easier than facing the challenge	working well generally; good rate of growth; compatible with culture	1. no alternative ever presented; 2. hospitals have done well; 3. until now, no power ideal driven phil of dereg in NY-NY Rep still descended from NRoek.	cost containment and quality
2. Key events	1. let go of waiver; 2. move to DRGs, HMO changes;	NA	DRGs switch; child health plan; regional pilots;	1. Medicare; economies won out; 2. DRGs; 3. HMOs; 4. movement to outpatient; 5. development bank	1. UC; 2. DRG;
3. Key institutions	Legislature; Gov.; DoH Comm.; St. budget director	Council on HCF; DoH; Assembly Speakers Health Care Board	legislature leadership; Gov.; Human Services. Deputy; DoH	Exco & BDeH; Sen. Kemp Hannon; Assembly Kenny Dewitt;	legislature, exco, DoH,
4. Dereg. advocates	business; Pataki admin.; some legislators; some hospital people	business council; blues	business council; billings, HMO conf;	not a leading voice at this time	Gov.'s office;
5. Dereg opponents	HANYS, but that may change; some consumers;	hospitals;	there aren't going to be a lot of defenders of RS;	voices not to walk away from GME and UC	hospitals
6. Govt. active or passive	passive	passive, huge turnover	active from Gov. on down	this is still a govt. that sees its responsibility to make the decisions.	active
7. Key political players	NA	HANYS, Bloch, consumers	hospital Assns; blues; HMOs; medical society	NA	business, AMA, hospitals
8. RS Idea	govt. protects people and assures access -- father knows best	NA	Medicaid patients should be treated the same, single tier of care; control overall payment system	1. stabilize hospital financing, 2. recognize UC, 3. stability in insurance, 4. bring feds into the solutions	hospital financial stability; UC
9. Dereg Idea	competitive marketplace approach	solve certain problems within dereg system	competitive environment	NYPHRM 6--evolving	managed care to control utilization
10. Ideas vs. interests in outcome	biggest factor is money, interests play a very large role; partially about ideas by people who have vision	interests	interests, but discussions on how to make a system that works best	policy driven involving the aggregation of interests	ideas
11. RS winner & losers	hospitals--mixed comm. ins--mixed BC--unclear HMOs--losers consumers--mixed business--losers labor--winners	hospitals--winners comm. ins--losers BC--losers HMOs--winners consumers--losers business--losers labor--losers	hospitals--winners comm. ins--winners BC--winners HMOs--winners consumers--winners business--now losers labor--mixed	hospitals--winners comm. ins--winners BC--loser nroo--winners consumers--winners business--winners labor--winners	hospitals--winners comm. ins--winners BC--winners HMOs--winners consumers--winners business--winners labor--winners
EXTRA			"one small design feature..."		

APPENDIX D

EXCERPTS FROM CHAPTER 23

(Massachusetts Universal Health Care Law, Acts and Resolves of 1988)

insurance under chapter one hundred and seventy-five, or any nonprofit hospital service corporation or health maintenance organization may apply to the commission for a discount from the charges it would otherwise be required to pay under sections seventy-eight to one hundred and two, inclusive, of this chapter. The commission shall grant a discount from charges on a prospective basis if it finds that the applicant has implemented an activity or program resulting in quantifiable savings to acute hospitals.

SECTION 8. Clause (b) of paragraph B of section 60 of said chapter 6A, as so appearing, is hereby amended by striking out, in lines 33 and 34, the words:-, as adjusted for productivity in accordance with sections fifty-one A and fifty-two.

SECTION 9. Section sixty-one of said chapter six A is hereby repealed.

SECTION 10. Said chapter 6A is hereby further amended by striking out section 63, as appearing in the 1986 Official Edition, and inserting in place thereof the following section:-

Section 63. Every acute hospital shall file with the commission within ninety days after the beginning of the fiscal year and at least once during the fiscal year, as deemed appropriate by the commission, a summary of revenues, costs and such statistical information as the commission may require in order to document the relationship of actual nonmedicare gross inpatient service revenue to approved nonmedicare gross inpatient service revenue, so that the commission may determine the extent to which excess revenue or deficit revenue was generated for such fiscal year. For this purpose, excess revenue for each fiscal year shall equal the amount by which actual nonmedicare gross inpatient service revenues exceed approved nonmedicare gross inpatient service revenues for such fiscal year, and deficit revenue shall equal the amount by which approved nonmedicare gross inpatient service revenues exceed actual approved nonmedicare gross inpatient service revenues for such fiscal year.

SECTION 11. Section sixty-three A of said chapter six A is hereby repealed.

SECTION 12. The first paragraph of section 65 of said chapter 6A, as appearing in the 1986 Official Edition, is hereby amended by striking out the second sentence.

SECTION 13. Said section 65 of said chapter 6A, as so appearing, is hereby further amended by striking out the second paragraph.

SECTION 14. Section 67 of said chapter 6A, as so appearing, is hereby amended by striking out, in line 11, the word "seventy-two" and inserting in place thereof the words:- one hundred and two.

SECTION 15. Sections sixty-eight and sixty-eight A of said chapter

six A are hereby repealed.

SECTION 16. The first paragraph of section 70 of said chapter 6A, as appearing in the 1986 Official Edition, is hereby amended by striking out, in line 2, the words "fifty to sixty-nine" and inserting in place thereof the words:- seventy-eight to one hundred and two.

SECTION 17. Section 73 of said chapter 6A, as so appearing, is hereby amended by striking out, in line 3, the words "fifty to seventy-two" and inserting in place thereof the words:- seventy-eight to one hundred and two.

SECTION 18. Sections seventy-four and seventy-five of said chapter six A are hereby repealed.

SECTION 19. The first paragraph of section 76 of said chapter 6A, as appearing in the 1986 Official Edition, is hereby amended by striking out the second and third sentences and inserting in place thereof the following sentence:- The amount of assistance for uninsured individuals for each fiscal year, subject to appropriation, shall be the amount provided in uncompensated care by the community health centers for the preceding fiscal year according to a distribution formula to be developed by the commission, after consultation with the Massachusetts league of community health centers and other interested parties.

SECTION 20. Said chapter 6A is hereby further amended by adding the following twenty-eight sections:-

Section 78. For all acute-care hospitals, excluding any comprehensive cancer center as defined in section thirty-one and any acute-care hospital which predominantly limits its admissions to patients under active diagnosis and treatment of eye, ears, nose and throat, approved gross patient service revenues for fiscal years nineteen hundred and eighty-eight, nineteen hundred and eighty-nine, nineteen hundred and ninety, and nineteen hundred and ninety-one, shall be determined in accordance with the provisions of sections seventy-nine through eighty-eight.

Any comprehensive cancer center may, at its option, elect to be exempt from sections seventy-nine to eighty-eight, inclusive, and establish, prospectively and retrospectively, its approved gross patient service revenues, its Blue Cross rate of payment and compliance with approved gross patient service revenues in accordance with section ninety-nine.

Any hospital which predominantly limits its admissions to patients under active diagnosis and treatment of eye, ears, nose and throat, may, at its option, elect to be exempt from sections seventy-nine to eighty-eight, inclusive, and establish, prospectively and retrospectively, its approved gross patient service revenue, its Blue Cross rate of payment and compliance with approved gross patient service revenues in accordance with section one hundred.

Every acute hospital shall establish its charges in accordance with the

provisions of this chapter. The charges established by an acute hospital for health care services rendered shall be uniform for all patients receiving comparable services.

Section 79. In addition to the adjustments prescribed in sections eighty to eighty-two A, inclusive, the patient care costs of certain hospitals shall be adjusted as described in paragraphs (a), (b) and (c) as follows:

(a) For fiscal years nineteen hundred and eighty-eight and nineteen hundred and eighty-nine, the patient care costs of certain hospitals shall be adjusted to incorporate a "low base cost adjustment" pursuant to the distribution methodology set forth in sections eighty-nine to ninety-eight, inclusive. Notwithstanding the provisions of said sections eighty-nine to ninety-eight, inclusive, the commission shall ensure that the sum of all individual hospital adjustments pursuant to this paragraph shall increase the projected payments from purchasers and third-party payors who pay on the basis of charges and a hospital service corporation by fifty-five million dollars for fiscal year nineteen hundred and eighty-eight; and by forty million dollars multiplied by one plus the fiscal year nineteen hundred and eighty-eight inflation adjustment pursuant to paragraph (d) of section eighty, for fiscal year nineteen hundred and eighty-nine.

(b) For fiscal years nineteen hundred and eighty-nine, nineteen hundred and ninety, and nineteen hundred and ninety-one, the patient care costs of certain hospitals shall be adjusted to incorporate a "prospective payment system price reduction adjustment" made pursuant to a distribution methodology adopted by the rate setting commission giving weight to the plan submitted by the Massachusetts Hospital Association pursuant to section thirty-two C. The purpose of said adjustment shall be to compensate acute hospitals for those shortfalls in medicare payments for which such hospitals are not compensated pursuant to section thirty-two C. Said distribution plan shall identify every hospital which is to receive this adjustment and shall specify, for each hospital, an amount of projected net patient service revenue which is to be received from a hospital service corporation and purchasers and third party payors who pay on the basis of charges. Said distribution plan shall be submitted to the commission by September first of each year and the commission shall ensure that the sum of all individual hospital adjustments shall increase the projected payments from purchasers and third-party payors who pay on the basis of charges and a hospital service corporation by an amount not to exceed twenty million dollars each year.

(c) Notwithstanding the provisions of paragraph (a) or of sections ninety and ninety-one, for fiscal years nineteen hundred and eighty-eight and nineteen hundred and eighty-nine, the patient care costs of Whidden Hospital shall be adjusted to incorporate a "low cost case mix adjustment" calculated pursuant to a distribution methodology set forth in section ninety-eight A. The commission shall ensure that the adjustment pursuant to this paragraph shall increase the projected payments from purchasers and third party payors who pay on the basis of charges and a hospital service corporation by one-half the amount of the adjustment provided by said section ninety-eight A for fiscal year

nineteen hundred and eighty-eight, and by one-half the amount of the adjustment provided by said section ninety-eight A, multiplied by one plus the fiscal year nineteen hundred and eighty-eight inflation adjustment, for fiscal year nineteen hundred and eighty-nine.

Section 80. For fiscal year nineteen hundred and eighty-eight, patient care costs for each acute hospital shall be determined in accordance with the following provisions and calculations:

(a) The fiscal year nineteen hundred and eighty-seven total patient care costs shall include the following provisions:

(i) all hospital agreement twenty-nine base year adjustments and exceptions shall be included at the amount approved or audited by the commission as of December eleventh, nineteen hundred and eighty-seven, except that where a formal settlement agreement was executed between Blue Cross and the hospital prior to December eleventh, nineteen hundred and eighty-seven, the amounts included in said settlement shall be the amounts included in this adjustment;

(ii) absent a commission approved amount as of December eleventh, nineteen hundred and eighty-seven, the amount to be included shall be that amount formally recommended for approval by Blue Cross and included as an adjustment to the appropriate year's hospital agreement twenty-nine year end maximum allowable cost report or as formally agreed to in writing by Blue Cross and the hospital as of April first, nineteen hundred and eighty-eight. No other adjustment shall be made;

(iii) the hospital agreement twenty-nine disputes of Baystate Medical Center, Marlborough Hospital and Goddard Memorial Hospital formally filed prior to December eleventh, nineteen hundred and eighty-seven, when they are resolved, and the hospital agreement twenty-nine dispute of Lawrence Memorial Hospital of Medford when it is resolved. No other adjustment shall be made;

(iv) all hospital agreement thirty recurring base year adjustments and exceptions approved by the commission. The commission shall within one hundred and eighty days after final passage of this act resolve all outstanding hospital agreement thirty base year adjustments and exceptions. Hospitals shall retain the right to appeal any commission disallowances of hospital agreement thirty exceptions and base year adjustments to the division of administrative law appeals;

(v) the commission shall complete all outstanding audits as of September first, nineteen hundred and eighty-eight. The nineteen hundred and eighty-seven maximum allowable cost shall be adjusted to reflect the effects of all resolved audits. Hospitals shall retain the right to appeal audit adjustments to the division of administrative law appeals;

(vi) fiscal year nineteen hundred and eighty-seven total patient care costs as calculated pursuant to hospital agreement thirty schedule A.O. line twelve of year-end per-review filing and as adjusted by the provisions stipulated in subparagraphs (i) through (v) of this paragraph shall be further adjusted by subtracting lines nine, ten and eleven of said schedule A.O., as adjusted. This result multiplied by ninety-four and twelve hundredths per cent shall constitute fiscal year nineteen hundred and eighty-seven maximum allowable costs.

(b) Said maximum allowable costs shall be further adjusted in such a

manner as to ensure that the projected payments of a hospital service corporation and purchasers and third party payors who pay on the basis of charges will include the amount of net revenue adjustment, if any, provided pursuant to paragraphs (a) and (c) of section seventy-nine.

(c) Said fiscal year nineteen hundred and eighty-seven maximum allowable costs shall be further adjusted by adding or subtracting, as appropriate, one-half of the difference between the inpatient services volume allowance provided in line eight of schedule A.O of the nineteen hundred and eighty-seven year-end filing per-review appendix D maximum allowable cost report and a revised inpatient services volume allowance calculated on the basis of formulas contained in hospital agreement thirty, but utilizing a marginal cost allowance of one hundred per cent. Both the original fiscal year nineteen hundred and eighty-seven inpatient services volume allowance and the revised fiscal year nineteen hundred and eighty-seven inpatient services volume allowance shall be calculated using a conversion program which corrects for inconsistencies resulting from coding and grouper changes between fiscal year nineteen hundred and eighty-four and fiscal year nineteen hundred and eighty-seven.

The following hospitals: Cape Cod, Martha's Vineyard, Nantucket Cottage, North Adams Regional, North Shore Children's and Saint Margaret's shall be exempted from said volume adjustment if an election is made upon execution of the successor agreement to hospital agreement thirty to continue to use the hospital agreement thirty inpatient volume adjustment allowances pursuant to paragraph (f).

(d) Fiscal year nineteen hundred and eighty-seven maximum allowable costs as adjusted pursuant to paragraphs (a) through (c) shall then be multiplied by the fiscal year nineteen hundred and eighty-eight inflation adjustment. Said inflation adjustment shall be equal to the sum of: (i) the composite inflation factor calculated in accordance with the methodology described in hospital agreement thirty utilizing May inflation projections, or February inflation projections in the case of hospitals with fiscal years ending on June thirtieth, and (ii) two one-hundredths. Revenue attributable to said two one-hundredths shall provide for certain wage increases for technicians, nurses, nursing aides, orderlies and attendants. No carry forward of underprojections or overprojections from the preceding year shall be included.

(e) Said fiscal year nineteen hundred and eighty-seven maximum allowable costs, as adjusted pursuant to paragraphs (b) through (d), shall be further adjusted, if necessary, to increase them to an amount equal to fiscal nineteen hundred and eighty-seven maximum allowable costs determined pursuant to paragraph (a) multiplied by a factor of one and forty-six thousandths.

(f) Fiscal year nineteen hundred and eighty-seven maximum allowable costs determined pursuant to paragraph (d) or (e), as applicable, shall be further adjusted by incorporating a nineteen hundred and eighty-eight volume adjustment which shall be calculated in accordance with the following conditions:

(i) all inpatient and outpatient volume adjustments shall utilize the same statistics as were utilized in hospital agreement thirty to measure

volume changes and shall be computed on a cost base which has been adjusted for the level of productivity included in the last year of hospital agreement thirty;

(ii) the inpatient, routine outpatient, surgical day care, and emergency service volume adjustments shall be calculated on the basis of a marginal cost allowance of one hundred per cent and there shall be no corridors applied;

(iii) the outpatient ancillary service volume adjustments shall be calculated on the basis of a marginal cost allowance of sixty per cent and there shall be no corridors applied;

(iv) in determining the inpatient volume allowance for fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one, the statistical base shall be case-mix adjusted discharges, including all transfers of inpatients from an acute hospital to another facility.

The commission shall ensure that the changes in volume are calculated in such a way as to accurately adjust for any coding and grouper changes which have been implemented; and to accurately account for discharges assigned a zero weight under the New Jersey weighting system. Such adjustments may take one or more than one of the following forms but shall not be limited to the options outlined: (a) restatement of all fiscal years into a form consistent with the coding principles and grouper utilized in fiscal year nineteen hundred and eighty-four or nineteen hundred and eighty-seven; (b) restatement of the rate year into a form consistent with the coding principles and grouper utilized in the year preceding the rate year; (c) restatement of the rate year and year preceding the rate year to account for any updates made by the state of New Jersey in its weighting system which more appropriately reflect the coding principles and grouper being utilized; and (d) development by Blue Cross and the Massachusetts hospital association of weights for discharges assigned a zero weighting under the New Jersey system.

In carrying out its rights and responsibilities granted under this paragraph, the commission must inform hospitals by no later than April thirtieth of the rate year, how the change in case mix adjusted discharges is to be measured for that year. Said determination shall be made only after a series of public hearings has taken place and the commission shall consider the comments of all interested parties in making its final determination.

If Blue Cross and the Massachusetts hospital association have failed to agree on a methodology for deriving weights for discharges assigned a zero weighting by June thirtieth of the rate year, hospitals may submit individual methodologies to the commission for approval and subsequent incorporation.

(v) the following hospitals: Cape Cod, Martha's Vineyard, Nantucket Cottage and North Adams Regional, may elect to participate under the terms and conditions as described in volume option one of hospital agreement thirty. The downside corridors under this volume options shall be twenty-eight per cent, thirty-five per cent, forty-two per cent and forty-nine per cent in fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one respectively;

(vi) the following hospitals: North Shore Children's and St. Margaret's, may elect to continue under the volume adjustment as defined as volume option two in hospital agreement thirty. The downside corridors under this volume options shall be ten per cent, twelve per cent, fourteen per cent and sixteen per cent in fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one respectively.

The amount of fiscal year nineteen hundred and eighty-seven maximum allowable costs, as adjusted pursuant to paragraphs (a) through (f), shall be termed the "fiscal year nineteen hundred and eighty-eight adjusted prior year costs".

(g) Fiscal year nineteen hundred and eighty-seven maximum allowable costs as adjusted pursuant to paragraph (f) shall be further adjusted by adding fiscal year nineteen hundred and eighty-eight depreciation, amortization, interest, determination of need capital cost and other capital costs defined pursuant to hospital agreement thirty. The fiscal year nineteen hundred and eighty-eight dollar amount of said depreciation, amortization, interest, determination of need capital costs and other capital costs that was subject to productivity adjustment in the last year of hospital agreement thirty shall be multiplied by ninety-four and twelve one-hundredths per cent. The remaining fiscal year nineteen hundred and eighty-eight dollar amount shall be allowed in full. The sum of the productivity adjusted portion and the amount allowed in full shall be the adjustment.

(h) Said fiscal year maximum allowable costs shall be further adjusted by adding any incremental costs incurred subsequent to October first, nineteen hundred and eighty-seven associated with government-mandated requirements mandated subsequent to October first, nineteen hundred and eighty-six and approved by the commission. For purposes of this paragraph, government-mandated requirements shall mean the incremental costs for each acute-care hospital resulting from its compliance with any governmental requirement whether established by statute, regulation or governmental ordinance and shall be allowed on the basis of incurred costs.

(i) Said fiscal year nineteen hundred and eighty-seven adjusted maximum allowable costs shall be further adjusted by adding any incremental operating costs associated with approved determination of need projects. Said costs shall be subject to commission approval pursuant to criteria utilized during the term of hospital agreement thirty. In addition, in the case of the department of mental health's approved special projects, the maximum allowable costs shall be further adjusted by an amount, to be determined by the commission, which will provide an incentive for hospitals to undertake said projects, provided that said incentive adjustment shall in no case exceed ten per cent of incremental operating costs.

(j) Said fiscal year nineteen hundred and eighty-seven maximum allowable costs shall be further adjusted to incorporate actual malpractice costs, and sick, vacation and earned time accruals, which are applicable in accordance with provisions contained in hospital agreement thirty. The fiscal year nineteen hundred and eighty-eight

dollar amount of actual malpractice costs and sick, vacation and earned time accruals that was subject to productivity adjustment in the last year of hospital agreement thirty shall be multiplied by ninety-four and twelve one-hundredths per cent. The remaining fiscal year nineteen hundred and eighty-eight dollar amount shall be allowed in full. The sum of the productivity adjusted portion and the amount allowed in full shall be the adjustment.

(k)(i) Fiscal year nineteen hundred and eighty-seven maximum allowable costs, as adjusted pursuant to paragraphs (a) to (j), inclusive, shall constitute fiscal year nineteen hundred and eighty-eight patient care costs for purposes of determining fiscal year nineteen hundred and eighty-eight approved gross patient service revenue pursuant to section eighty-three.

(ii) Each acute hospital which receives an adjustment pursuant to paragraph (b) or (c) shall expend a sufficient portion of its fiscal year nineteen hundred and eighty-eight approved gross patient service revenues upon expenditures in the six nonmanagement labor categories so designated under schedule C.1.O of appendix D of hospital agreement thirty to ensure that the hospital will not be subject to a labor cost recovery pursuant to section eighty-two.

Section 80A. Except as otherwise provided for in section one hundred and one, a hospital which had an inpatient volume decline of twenty per cent or more from fiscal year nineteen hundred and eighty-four through fiscal year nineteen hundred and eighty-seven and which operated at an occupancy rate of fifty per cent or less in fiscal year nineteen hundred and eighty-seven, shall not be entitled to the adjustment described in paragraph (a) or (c) of section seventy-nine or to the adjustment described in paragraph (e) of section eighty. For the purposes of this section, volume decline shall be measured using case-mix adjusted discharges calculated in the same manner as in paragraph (e) of section eighty, and occupancy rate shall be measured using total fiscal year nineteen hundred and eighty-seven patient days for all services divided by the number of licensed end beds multiplied by three hundred and sixty-five. Licensed beds shall be calculated by taking the number of end beds as reported in rate setting commission form 403, schedule III, column 4, line 14 and subtracting any beds reduced or converted by any determination of need approved or on file as of January first, nineteen hundred and eighty-eight, and further subtracting any beds temporarily removed from service if such removal has been granted by the department of public health pursuant to licensure rules and regulations for hospitals. Code of Massachusetts Regulations, section 130.121(C)(D), and if such removal was effective prior to October first, nineteen hundred and eighty-seven. Occupancy rate shall be calculated by taking the total patient days as reported on rate setting commission form 403, schedule III, column 6, line 14 and dividing by the product of end beds, as hereinbefore described, times three hundred and sixty-five expressed as a percentage.

Except as otherwise provided for in section one hundred and one, an institution which experienced an occupancy rate of forty per cent or less in fiscal year nineteen hundred and eighty-seven shall not be entitled to

the adjustment described in paragraph (a) or (c) of section seventy-nine or to the adjustment described in paragraph (e) of section eighty. Occupancy rate shall be measured as described in the preceding paragraph.

Notwithstanding the foregoing, the following types of hospitals shall be entitled to the adjustments described in paragraphs (a) and (c) of section seventy-nine and paragraph (e) of section eighty regardless of their rates of volume decline or occupancy: (1) a sole community provider; (2) a specialty hospital; or (3) a comprehensive cancer center.

Section 81. For fiscal year nineteen hundred and eighty-nine, patient care costs for each acute hospital shall be determined in accordance with the following provisions:

(a) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs for each acute hospital shall be adjusted to reflect the incremental costs of prior year recurring determination of need exceptions which represent full year costs.

(b) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted in such a manner as to ensure that the projected payments of a hospital service corporation and third party payors who pay on the basis of charges will include the amount of net revenue adjustment, for fiscal year nineteen hundred and eighty-nine, if any, provided pursuant to paragraphs (a) and (c) of section seventy-nine.

(c) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted by adding or subtracting, as appropriate, one-half of the difference between the inpatient services volume allowance and the revised inpatient services volume allowance calculated pursuant to paragraph (c) of section eighty, multiplied by the fiscal year nineteen hundred and eighty-eight inflation adjustment as determined pursuant to paragraph (d) of said section eighty.

The following hospitals: Cape Cod, Martha's Vineyard, Nantucket Cottage, North Adams Regional, North Shore Children's and St. Margaret's shall be exempted from said volume adjustment if an election was made in fiscal year nineteen hundred and eighty-eight to continue under the hospital agreement thirty inpatient volume adjustment allowances as described in paragraph (f) of said section eighty.

(d) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs, as adjusted pursuant to paragraphs (a) to (c), inclusive, shall then be multiplied by the fiscal year nineteen hundred and eighty-nine inflation adjustment. Said inflation adjustment shall be equal to the sum of: (i) the composite inflation factor calculated in accordance with the methodology described in hospital agreement thirty utilizing May inflation projections, or February inflation projections in the case of hospitals with fiscal years ending on June thirtieth, and (ii) one one-hundredth. Revenue attributable to said one one-hundredth shall provide for certain wage increases for technicians, nurses, nursing aides, orderlies and attendants. No carry forward of underprojections or overprojections from the preceding year shall be included.

(e) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted in such a manner as to ensure that the

projected payments of a hospital service corporation and purchasers and third party payors who pay on the basis of charges will include the amount of net revenue adjustment, if any, provided pursuant to paragraph (b) of section seventy-nine.

(f) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs as adjusted pursuant to paragraphs (a) to (e), inclusive, shall be further adjusted by incorporating a nineteen hundred and eighty-nine volume adjustment which shall measure volume changes between fiscal year nineteen hundred and eighty-eight and fiscal year nineteen hundred and eighty-nine and which shall be calculated in accordance with the conditions prescribed in paragraph (f) of section eighty.

The resultant amount shall be termed the "fiscal year nineteen hundred and eighty-nine adjusted prior year costs".

(g) Said fiscal year nineteen hundred and eighty-nine adjusted prior year costs shall be further adjusted by adding fiscal year nineteen hundred and eighty-nine depreciation, amortization, interest, determination of need capital costs and other capital costs defined pursuant to hospital agreement thirty. The fiscal year nineteen hundred and eighty-nine dollar amount of said depreciation, amortization, interest, determination of need capital costs and other capital costs that was subject to productivity adjustment in the last year of hospital agreement thirty shall be multiplied by ninety-four and twelve one-hundredths per cent. The remaining fiscal year nineteen hundred and eighty-nine dollar amount shall be allowed in full. The sum of the productivity adjusted portion and the amount allowed in full shall be the adjustment.

(h) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted by adding any incremental costs associated with government mandated requirements as defined in paragraph (h) of section eighty.

(i) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted by adding any incremental operating costs associated with approved determination of need projects implemented in fiscal year nineteen hundred and eighty-nine. Said costs shall be subject to commission approval pursuant to criteria utilized during the term of hospital agreement thirty. In addition, in the case of the department of mental health's approved special projects, the maximum allowable costs shall be further adjusted by an amount, to be determined by the commission, which will provide an incentive for hospitals to undertake said projects, provided that said incentive adjustment shall in no case exceed ten per cent of incremental operating costs.

(j) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted to incorporate actual fiscal year nineteen hundred and eighty-nine malpractice costs, and sick, vacation, and earned time accruals which are applicable in accordance with provisions contained in hospital agreement thirty. The fiscal year nineteen hundred and eighty-nine dollar amount of actual malpractice costs and sick, vacation and earned time accruals that was subject to productivity adjustment in the last year of hospital agreement thirty shall be multiplied by ninety-four and twelve one-hundredths per cent. The

remaining fiscal year nineteen hundred and eighty-nine dollar amount shall be allowed in full. The sum of the productivity adjusted portion and the amount allowed in full shall be the adjustment.

(k) Each acute hospital shall report to the commission its actual expenses during fiscal years nineteen hundred and eighty-seven and nineteen hundred and eighty-eight for each of the six nonmanagement labor categories so designated under schedule C.1.O of appendix D of hospital agreement thirty.

(l)(i) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs, as adjusted pursuant to paragraphs (a) to (j), inclusive, shall constitute fiscal year nineteen hundred and eighty-nine patient care costs for purposes of determining fiscal year nineteen hundred and eighty-nine approved gross patient service revenues pursuant to section eighty-three.

(ii) Each acute hospital which receives an adjustment pursuant to paragraph (b) or (c) shall expend a sufficient portion of its fiscal year nineteen hundred and eighty-nine approved gross patient service revenues upon expenditures in said six nonmanagement labor categories to ensure that the hospital will not be subject to a labor cost recovery pursuant to section eighty-two.

Section 82. For fiscal year nineteen hundred and ninety patient care costs for each acute hospital shall be determined in a manner consistent with section eighty-one exclusive of paragraphs (b) and (c), and substituting "fiscal year nineteen hundred and eighty-nine" and "fiscal year nineteen hundred and ninety", respectively, for "fiscal year nineteen hundred and eighty-eight" and "fiscal year nineteen hundred and eighty-nine" where appearing in section eighty-one.

Fiscal year nineteen hundred and ninety approved revenues of any hospital which received an adjustment pursuant to paragraph (b) or (c) of section eighty or paragraph (b) or (c) of section eighty-one shall be further adjusted by subtracting a labor cost recovery, if any. The labor cost recovery shall be determined as follows:

(a)(i) The fiscal year nineteen hundred and eighty-nine actual expenses for each of the six nonmanagement labor categories so designated under schedule C.1.O of appendix D of hospital agreement thirty shall be adjusted by subtracting the product of the inflation adjustments associated with said categories which were provided pursuant to paragraph (d) of section eighty and paragraph (d) of section eighty-one, multiplied by the percentage of total gross patient service revenue attributable to purchasers and third party payors who pay on the basis of charges and a hospital service corporation; the results shall then be summed for all six such categories.

(ii) The fiscal year nineteen hundred and eighty-seven actual expenses for the sum of such six nonmanagement labor categories shall be adjusted by adding eighty per cent of the net revenue received from purchasers and third party payors who pay on the basis of charges and a hospital service corporation due to adjustments made pursuant to paragraphs (b) and (c) of section eighty and paragraphs (b) and (c) of section eighty-one.

(iii) Subtract the amount calculated in subparagraph (i) from the

amount calculated in subparagraph (ii).

(iv) If the amount calculated in subparagraph (iii) is positive, a labor cost recovery shall be applicable. The labor cost recovery shall be the lesser of the amount in subparagraph (iii) or eighty per cent of the net revenue received from purchasers and third party payors who pay on the basis of charges and a hospital service corporation as a result of adjustments made pursuant to paragraphs (b) and (c) of section eighty and paragraphs (b) and (c) of section eighty-one.

(v) Fiscal year nineteen hundred and ninety approved revenues shall be adjusted in such a manner as to ensure that the projected payments of purchasers and third party payors who pay on the basis of charges and a hospital service corporation are reduced by the amount of the labor cost recovery, if any, calculated pursuant to subparagraph (iv).

(b) The commission may waive any or all of the labor cost recovery pursuant to paragraph (a) upon request for any hospital which demonstrates that such recovery would inappropriately penalize the hospital and its nonmanagement employees, because the hospital's failure to expend sufficient amounts for nonmanagement labor expenses to avoid said recovery is the result of staff reductions necessary to accommodate a volume decline or of inability to hire employees due to a shortage of available personnel.

(c) Each acute hospital shall report its actual expenses during fiscal years nineteen hundred and eighty-seven and nineteen hundred and eighty-nine for each of the six nonmanagement labor categories so designated under schedule C.1.O of appendix D of hospital agreement thirty.

Section 82A. For fiscal year nineteen hundred and ninety-one, patient care costs for each hospital shall be determined in a manner consistent with section eighty-one, exclusive of paragraphs (b) and (c), and substituting "fiscal year nineteen hundred and ninety," and "fiscal year nineteen hundred and ninety-one," respectively.

Fiscal year nineteen hundred and ninety-one approved revenues of any hospital which received an adjustment pursuant to paragraph (b) or (c) of section eighty or paragraph (b) or (c) of section eighty-one and which was subject to a labor cost recovery pursuant to section eighty-two shall be further adjusted to reflect a labor cost recovery, if any. The labor cost recovery shall be determined as follows:-

(a)(i) The fiscal year nineteen hundred and ninety actual expenses for each of the six nonmanagement labor categories so designated under schedule C.1.O of Appendix D of hospital agreement thirty shall be adjusted by subtracting the product of: the sum of (i) the inflation adjustments associated with said categories which were provided pursuant to paragraph (d) of section eighty and paragraph (d) of section eighty-one and (ii) the comparable inflation adjustments provided for fiscal year nineteen hundred and ninety; multiplied by the percentage of total gross patient service revenue attributable to purchasers and third party payors who pay on the basis of charges and a hospital service corporation; the results shall then be summed for all six such categories.

(ii) The fiscal year nineteen hundred and eighty-seven actual expenses for the sum of such six nonmanagement labor categories shall be

adjusted by adding eighty per cent of the net revenue received from purchasers and third party payors who pay on the basis of charges and a hospital service corporation due to adjustments made pursuant to paragraphs (b) and (c) of section eighty and paragraphs (b) and (c) of section eighty-one.

(iii) Subtract the amount calculated in subparagraph (i) from the amount calculated in subparagraph (ii).

(iv) If the amount calculated in subparagraph (iii) is positive, a labor cost recovery shall be applicable. The labor cost recovery shall be the lesser of the amount in subparagraph (iii) or eighty per cent of the net revenue received from purchasers and third party payors who pay on the basis of charges and a hospital service corporation due to adjustments made pursuant to paragraphs (b) and (c) of section eighty and paragraphs (b) and (c) of section eighty-one.

(v) Fiscal nineteen hundred and ninety-one approved revenues shall be adjusted in such a manner as to ensure that the projected payments of purchasers and third party payors who pay on the basis of charges and a hospital service corporation are reduced by the amount of the labor cost recovery, if any, calculated pursuant to subparagraph (iv).

(b) The commission may waive any or all of the labor cost recovery pursuant to paragraph (a) upon request for any hospital which demonstrates that such recovery would inappropriately penalize the hospital and its nonmanagement employees, because the hospital's failure to expend sufficient amounts for nonmanagement labor expenses to avoid said recovery is the result of staff reductions necessary to accommodate a volume decline or of inability to hire employees due to a shortage of available personnel.

Section 83. For fiscal years nineteen hundred and eighty-eight to nineteen hundred and ninety-one, approved gross patient service revenue shall be calculated in the following manner:

(a) Each year the malpractice adjustment for medicare shortfall calculated pursuant to the principles governing hospital agreement thirty shall be added to fiscal year patient care costs as calculated pursuant to sections eighty to eighty-two A.

(b) Patient care costs for fiscal years nineteen hundred and eighty-eight to nineteen hundred and ninety-one, as calculated pursuant to section eighty to eighty-two A and as adjusted pursuant to paragraph (a), shall then be multiplied by the proportion of charges attributable to those purchasers and third-party payors who pay on the basis of charges and to a hospital service corporation, excluding those charges associated with free care, bad debt and services rendered to Title XIX recipients. Said product shall be known as private sector patient care costs.

(c) Private sector patient care costs as computed according to paragraph (b) shall then be further adjusted for a working capital allowance as computed in accordance with hospital agreement thirty, and the sum shall be multiplied by one plus the uniform statewide uncompensated care allowance as computed according to section eighty-seven. The resulting product shall be termed the private sector liability.

(d) The private sector liability as computed according to paragraph

(c) shall be divided by: (i) the proportion of charges attributable to purchasers and third party payors who pay on the basis of charges, excluding those charges associated with free care and bad debt services, multiplied by one plus the uniform differential; plus (ii) the proportion of charges attributable to a hospital service corporation. The result of this division shall be known as the Blue Cross basis of payment.

(e) The Blue Cross basis of payment, as calculated in accordance with paragraph (d) shall be further multiplied by one plus the uniform differential and the resulting product shall be termed approved gross patient service revenue for fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one respectively.

Section 84. For fiscal years nineteen hundred and eighty-eight to nineteen hundred and ninety-one, approved nonmedicare gross inpatient service revenue shall be calculated as follows:

Actual gross outpatient service revenue shall be subtracted from approved gross patient service revenue and the resulting difference shall be known as approved gross inpatient service revenue. Approved gross inpatient service revenue shall then be multiplied by: (i) the ratio of the per cent of actual gross inpatient service revenue attributable to nonmedicare patients to the per cent of case mix adjusted discharges attributable to nonmedicare patients. Said calculation shall utilize gross inpatient service revenues and case mix adjusted discharges for the final six months of the fiscal year beginning on October first, nineteen hundred and eighty-three and the first six months of the fiscal year beginning on October first, nineteen hundred and eighty-four and shall be further adjusted, if applicable, pursuant to changes made in accordance with paragraph (f) of section eighty; and (ii) the per cent of case mix adjusted discharges attributable to nonmedicare patients in the rate year.

The resultant amount shall be termed the approved nonmedicare gross inpatient service revenue without compliance; provided, however, that if an acute hospital appealed to the Division of Administrative Law Appeals the Commission's determination of approved gross inpatient service revenue for such acute hospital for the fiscal years beginning October first, nineteen hundred and eighty-two or October first, nineteen hundred and eighty-three and the Commission affecting the pendency of such appeal ordered such acute hospital to adjust its charges to comply with approved gross patient service revenue which order affected all or part of the final six months of the fiscal year beginning October first, nineteen hundred and eighty-three and the first six months of the fiscal year beginning October first, nineteen hundred and eighty-four, and which order of the Commission was determined by the Division not to have been in accordance with the approved gross patient service revenue determined by the Division for such acute hospital, then the calculation of the ratio of the per cent of actual gross inpatient service revenue attributable to nonmedicare patients to the per cent of casemix adjusted discharges attributable to nonmedicare patients shall utilize gross inpatient service revenues and casemix adjusted discharges for the final six months of the fiscal year beginning on October first, nineteen hundred and eighty-two and the first six months of the fiscal year beginning on October first, nineteen hundred and eighty-three.

Section 85. Beginning with fiscal year nineteen hundred and eighty-eight, and for each fiscal year thereafter, approved nonmedicare gross inpatient service revenue, without compliance, shall be adjusted to reflect any deficit or excess revenue earned in the preceding fiscal year. The dollar amount of the deficit or excess revenue shall be multiplied by one plus the average prime interest rate for such preceding fiscal year plus two per cent and the product shall be the dollar amount added to or subtracted from approved nonmedicare gross inpatient service revenue, without compliance, and the resultant amount shall be termed approved nonmedicare gross inpatient service revenue.

Section 86. Notwithstanding the provisions of sections eighty-four and eighty-five, in computing the amount of each acute hospital's deficit or excess revenue in any fiscal year, the commission shall, subject to regulations to be promulgated by said commission, increase or decrease a hospital's approved nonmedicare gross inpatient service revenue to the extent that it determines that the deficit or excess in the hospital's nonmedicare gross inpatient service revenue is attributable to a change from the base period to said fiscal year in the number and type of services provided to nonmedicare patients, as compared to medicare patients, which change is caused by a change in the relative clinical characteristics and medical needs of nonmedicare and medicare patients not reflected in the measurement of case mix adjusted discharges.

Section 87. (1) For purposes of this section, terms used herein shall have the meanings given them in section one of chapter one hundred and eighteen F. The uniform statewide allowance for uncompensated care for each hospital for each fiscal year beginning in fiscal year nineteen hundred and eighty-eight shall be calculated by the commission by dividing the amount of total private sector liability to the pool for such fiscal year by an amount equal to the sum of: (a) the sum for all acute hospitals of the private sector share of projected patient care costs for such fiscal year, and (b) a working capital allowance specified by the commission for such fiscal year. The amount of total private sector liability to the pool for this purpose shall equal: three hundred twenty-five million dollars for fiscal year nineteen hundred and eighty-eight; three hundred eighteen million, five hundred thousand dollars for fiscal year nineteen hundred and eighty-nine; three hundred twelve million dollars for fiscal year nineteen hundred and ninety; and three hundred twelve million dollars minus the amount appropriated by the commonwealth for such fiscal year for coverage of hospitalization expenses of recipients of benefits under chapter one hundred and seventeen for fiscal year nineteen hundred and ninety-one.

(2) Prior to the beginning of each hospital fiscal year, the commission shall, using the most appropriate and accurate data available, estimate the uniform allowance for statewide uncompensated care. These estimates shall be updated, on a timely basis, as significant new information becomes available. The commission shall supply these data and estimates promptly to the department of medical security and shall audit the accounts of hospitals with respect to receipts and liabilities for uncompensated care in accordance with standards adopted by such department pursuant to section fifteen of chapter one hundred and

eighteen F.

Section 88. For fiscal years nineteen hundred and eighty-eight, nineteen hundred and eighty-nine, nineteen hundred and ninety, nineteen hundred and ninety-one, the interim rate of payment by a nonprofit hospital service corporation to acute hospitals under the successor agreement to hospital agreement thirty shall be at the level of billed charges multiplied by the ratio of: (a) one; to (b) the sum of one plus the uniform differential.

Section 89. For the purposes of sections eighty-nine to ninety-eight, inclusive, the following words shall have the following meanings unless the context clearly requires otherwise:

"Gross revenues", the total dollar amount of a hospital's charges for services rendered to patients in a fiscal year.

"RSC-403 form", the cost report as filed with the rate setting commission by each hospital for each of its fiscal years which has been designated by said commission as the "RSC-403 Form".

"Nineteen hundred and eighty-five MAC report", appendix D to an agreement between Blue Cross of Massachusetts, Inc. and a hospital, approved by the rate setting commission pursuant to section five of chapter one hundred and seventy-six A first taking effect on October first, nineteen hundred and eighty-four, as completed and filed by each hospital with the rate setting commission.

"Nineteen hundred and eighty-five total hospital expense", the total expense reported on schedule II, column 7, line 93 of each hospital's nineteen hundred and eighty-five RSC-403 form, less compensation to physicians reported on schedule IX, column 3, line 93 of said nineteen hundred and eighty-five RSC-403 form, and teaching costs reported on schedule II, column 3, lines 27, 28, and 29.

"Nineteen hundred and eighty-five major movable capital cost", the costs reported on schedule IX, column 7, line 94, of each hospital's nineteen hundred and eighty-five RSC-403 form.

"Noncapital hospital expense", the nineteen hundred and eighty-five total hospital expense less nineteen hundred and eighty-five major movable capital cost.

"Nineteen hundred and eighty-five gross revenues", the amount reported on schedule II, column 8, line 93 of each hospital's nineteen hundred and eighty-five RSC-403 form.

"Nineteen hundred and eighty-five inpatient revenue", the amount reported on schedule II, column 8, line 82 of each hospital's nineteen hundred and eighty-five RSC-403 form.

"Nineteen hundred and eighty-five inpatient admissions", the number of inpatient admissions reported on schedule III, column 9, line 14 of each hospital's nineteen hundred and eighty-five RSC-403 form.

"Nineteen hundred and eighty-five inpatient days", the number of patient days reported on schedule III, column 6, line 14 of each hospital's nineteen hundred and eighty-five RSC-403 form.

"The outpatient adjustment factor", nineteen hundred and eighty-five inpatient revenues divided by nineteen hundred and eighty-five gross revenues.

"Nineteen hundred and eighty-five adjusted admissions", for each

hospital, nineteen hundred and eighty-five inpatient admissions divided by the outpatient adjustment factor.

"Nineteen hundred and eighty-five adjusted patient days", for each hospital, nineteen hundred and eighty-five inpatient days divided by the outpatient adjustment factor.

"Net revenues", the actual dollar amount of payments received by a hospital for services provided to patients.

Section 90. Notwithstanding any law to the contrary, the commission shall identify low cost acute hospitals and shall allow each such hospital the low cost hospital adjustment hereinafter provided in sections eighty-nine to ninety-eight, inclusive.

Section 91. Each hospital's qualification for a low cost hospital adjustment shall be determined by:

(a) dividing nineteen hundred and eighty-five adjusted patient days into noncapital expense for each hospital, to derive its nineteen hundred and eighty-five noncapital costs per adjusted patient day;

(b) calculating two standard deviations below the median of all hospitals' nineteen hundred and eighty-five noncapital costs per adjusted patient day;

(c) assigning each hospital an increasing positive or increasing negative arabic number depending on its rank above or below said second standard deviation from the median calculated under clause (b);

(d) dividing nineteen hundred and eighty-five adjusted admissions into noncapital costs for each hospital to derive its nineteen hundred and eighty-five noncapital costs per adjusted admission;

(e) calculating two standard deviations below the median of all hospitals' nineteen hundred and eighty-five noncapital costs per adjusted admissions;

(f) assigning each hospital an increasing positive or increasing negative arabic number depending on its rank above or below said second standard deviation from the median calculated under clause (e);

(g) for each hospital sum the positive and negative arabic numbers assigned by clause (c) and (f) to derive its aggregate ranking.

Every hospital whose aggregate ranking of nineteen hundred and eighty-five noncapital costs per patient day and nineteen hundred and eighty-five noncapital costs per adjusted admission is less than zero, shall be deemed entitled to a low cost hospital adjustment; provided, however, St. Margaret's Hospital shall be entitled to a low cost hospital adjustment regardless of its aggregate ranking.

Section 92. For every hospital entitled to a low cost hospital adjustment whose greater individual negative ranking is for nineteen hundred and eighty-five noncapital costs per adjusted patient day, as assigned pursuant to clause (c) of the first paragraph of section ninety-one, the low cost hospital adjustment shall be the lesser of the noncapital cost per adjusted patient day recovery or the revenue reduction factor provided for by sections ninety-four and ninety-six.

Section 93. For every hospital entitled to a low cost hospital adjustment whose greater individual negative ranking is for nineteen hundred and eighty-five noncapital costs per adjusted admission, as assigned pursuant to clause (f) of the first paragraph of section

ninety-one, the low cost hospital adjustment shall be the lesser of the cost per adjusted admission recovery or the revenue restoration factor provided for by sections ninety-five and ninety-six.

Section 94. The noncapital cost per adjusted patient day recovery shall be calculated separately for each hospital whose low cost hospital adjustment is subject to section ninety-two. For each such hospital the noncapital cost per adjusted patient day recovery shall be equal to the difference between the nineteen hundred and eighty-five noncapital costs per adjusted patient day for all hospitals calculated pursuant to clause (b) of the first paragraph of section ninety-one, less the nineteen hundred and eighty-five noncapital costs per adjusted patient day for the individual hospital, calculated pursuant to clause (a) of the first paragraph of section ninety-one, multiplied by the individual hospital's nineteen hundred and eighty-five adjusted patient days as defined in section eighty-nine. The amount so calculated shall be increased or decreased by the percentage change reported for the Consumer Price Index (ALL URBAN) - Medical Care Services for New England - Data Resources, Inc., Health Care Cost - Regional Forecast between the last amount reported for nineteen hundred and eighty-five and the amount reported and projected through fiscal year nineteen hundred and eighty-eight by Data Resources, Inc.

Section 95. The noncapital cost per adjusted admission recovery shall be calculated separately for each hospital whose low cost hospital adjustment is subject to section ninety-three. For each such hospital the noncapital cost per adjusted admission recovery shall be equal to the difference between the nineteen hundred and eighty-five noncapital cost per adjusted admission calculated pursuant to clause (e) of the first paragraph of section ninety-one, less the nineteen hundred and eighty-five noncapital costs per adjusted admission for the individual hospital, calculated pursuant to clause (d) of the first paragraph of section ninety-one, multiplied by the individual hospital's nineteen hundred and eighty-five adjusted admissions as defined in section eighty-nine. The amount so calculated shall be increased or decreased by the percentage change reported for the Consumer Price Index (ALL URBAN) - Medical Care Services for New England - Data Resources, Inc., Health Care Cost - Regional Forecast between the last amount reported for nineteen hundred and eighty-five and the amount reported and projected through fiscal year nineteen hundred and eighty-eight by Data Resources, Inc.

Section 96. Each hospital's revenue restoration factor shall be calculated by:

(a) dividing revenue charged by the hospital to each of its payors by total hospital patient care related revenue reported on line 23, schedule V of its, as filed, nineteen hundred and eighty-three RSC-403 form to derive separate nineteen hundred and eighty-three fiscal year payor specific revenue to total revenue percentages;

(b) multiplying each payor specific revenue to total revenue percentage by a related fiscal year nineteen hundred and eighty-three payor productivity percentage of two per cent for medicare; zero per cent for Blue Cross; two per cent for medicaid; and one and four-tenths

per cent for all other payors;

(c) summing the percentages derived under clause (b) to derive the nineteen hundred and eighty-three hospital specific revenue restoration percentage;

(d) dividing revenue charged by the hospital to each of its payors by total hospital patient care related revenue reported on line 23, schedule V of each hospital's, as filed, nineteen hundred and eighty-four RSC-403 form to derive separate nineteen hundred and eighty-four fiscal year payor specific revenue to total revenue payor percentages;

(e) multiplying each payor specific revenue to total revenue percentage by a related fiscal year nineteen hundred and eighty-four payor productivity percentage of: four per cent for medicare; zero per cent for Blue Cross; four per cent for medicaid; and zero per cent for all other payors;

(f) summing the percentages derived under clause (e) to derive a hospital specific nineteen hundred and eighty-four revenue restoration percentage;

(g) dividing revenue charged by the hospital to each of its payors by total hospital patient care related revenue reported on line 23, schedule V of each hospital's, as filed, nineteen hundred and eighty-five RSC-403 form to derive separate nineteen hundred and eighty-five fiscal year payor percentages;

(h) multiplying each payor specific revenue to total revenue percentage by a related fiscal year nineteen hundred and eighty-five productivity percentage of: four per cent for medicare; two per cent for Blue Cross; six per cent for medicaid; and two per cent for all other payors;

(i) summing the percentages derived under clause (h) to derive a hospital specific nineteen hundred and eighty-five revenue restoration percentage;

(j) dividing revenue charged by the hospital to each of its payors by total hospital patient care related revenue reported on line 23, schedule V of each hospital's, as filed, nineteen hundred and eighty-six RSC-403 form to derive separate nineteen hundred and eighty-six fiscal year payor percentages;

(k) multiplying each payor specific revenue to total revenue percentage by a related fiscal year nineteen hundred and eighty-six productivity percentage of: two per cent for Blue Cross; three per cent for medicaid; and two per cent for all other payors;

(l) summing the percentages derived under clause (k) to derive a hospital specific nineteen hundred and eighty-six revenue restoration percentage;

(m) the nineteen hundred and eighty-seven revenue restoration percentage shall be the same calculation as provided for by clause (k), except that the productivity percentage for medicaid shall be two per cent;

(n) summing the revenue restoration percentages for nineteen hundred and eighty-three, nineteen hundred and eighty-four, nineteen hundred and eighty-five, nineteen hundred and eighty-six and nineteen hundred and eighty-seven calculated pursuant to clauses (c), (f), (i), (l), and (m)

to derive an aggregate hospital specific restoration percentage; and

(o) multiplying the aggregate hospital specific restoration percentage by the amount of maximum allowable costs reported by each hospital on line 14, schedule A.O of its as filed nineteen hundred and eighty-five fiscal year MAC report less the amount of capital costs reported on line 9, schedule A.O of said nineteen hundred and eighty-five MAC report as filed by the individual hospital. The amount so calculated shall constitute each hospital's revenue restoration factor and shall be increased or decreased by the percentage change reported for the Consumer Price Index (ALL URBAN) - Medical Care Services for New England - Data Resources, Inc., Health Care Cost - Regional Forecast between the last amount reported for nineteen hundred and eighty-five and the amount reported and projected through fiscal year nineteen hundred and eighty-eight by Data Resources, Inc.

Section 97. The commission shall provide that the low cost hospital adjustment shall be included within any allowance of gross revenues, charges, costs, maximum allowable costs, reasonable financial requirements, rates, prices or the like so that each hospital, in addition to any other allowances as are permitted by law, receives net revenues which reflect its low cost adjustment.

Section 98. The commission shall, after a public hearing, adopt regulations to implement sections eighty-nine to ninety-eight, inclusive. At a minimum said regulations shall set forth the low cost hospital adjustment due to each hospital. All data and computation for such low cost hospital adjustments shall be published no later than twenty-one days prior to the public hearing.

Section 98A. Notwithstanding any provision of law to the contrary, the commission shall identify a case-mix adjusted low cost hospital and allow Whidden hospital the adjustment provided for in paragraph (c) of section seventy-nine. Whidden hospital's qualification for a case-mix adjusted low cost hospital adjustment shall be determined by:

(a) calculating for said hospital's "1985 case mix", which shall be defined as, for said hospital, the average cost weight per discharge calculated by dividing the total case mix adjusted discharges by the total discharges on said hospital's merged billing tapes submitted to said commission for the entire year of nineteen hundred and eighty-five.

(b) assigning to said hospital a "case mix index", which shall be defined as, for said hospital, that hospital's 1985 case mix divided by the mean 1985 case mix of all acute hospitals in the commonwealth as calculated above.

(c) determining the 1985 case mix adjusted cost per patient day, by dividing said hospital's 1985 noncapital cost per adjusted patient day cost calculated pursuant to clause (a) of section ninety-one by its case mix index.

(d) calculating two and one-half standard deviations below the median of all hospitals' 1985 case mix adjusted costs per patient day.

(e) assigning said hospital an increasing positive or increasing negative arabic number depending on its rank above or below said second and one-half standard deviation from the median calculated under clause (d).

(f) determining the 1985 case mix adjusted cost per admission by

dividing said hospital's 1985 noncapital cost per adjusted admission calculated pursuant to clause (d) of section ninety-one by its case mix index.

(g) calculating two and one-half standard deviations below the median of all hospitals' 1985 case mix adjusted costs per admission.

(h) assigning said hospital an increasing positive or increasing negative arabic number depending on its rank above or below said second and one-half standard deviation from the median calculated under clause (g).

(i) for said hospital sum the positive and negative arabic numbers assigned by clauses (e) and (h) to derive its aggregate ranking.

(j) Whidden hospital shall be deemed entitled to a case mix adjusted low cost hospital adjustment, provided that such hospital is not otherwise eligible for an adjustment under paragraph (a) of section seventy-nine.

The case mix adjusted low cost hospital adjustment shall be calculated consistent with the methodology employed in sections ninety-two to ninety-eight, inclusive; provided, however, that for purposes of this section the following substitution of terms appearing in said sections ninety-two to ninety-eight shall be made:

"case mix adjustment low cost hospital adjustment" for "low cost hospital adjustment",

"1985 case mix adjusted cost per patient day" for "1985 noncapital costs per adjusted patient day",

"case mix adjusted patient day recovery" for "noncapital cost per adjusted patient day recovery",

"1985 case mix adjusted cost per admission" for "1985 noncapital costs per adjusted admission",

"case mix adjusted admission recovery" for "cost per adjusted admission recovery",

clause (c) of this paragraph for clause (a) of section ninety-one, clause (d) of this paragraph for clause (b) of said section ninety-one, clause (e) of this paragraph for clause (c) of said section ninety-one, clause (f) of this paragraph for clause (d) of said section ninety-one, clause (g) of this paragraph for clause (e) of said section ninety-one, clause (h) of this paragraph for clause (f) of said section ninety-one.

Section 99. For fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one, a comprehensive cancer center may, at its option, elect to establish prospectively and retrospectively, its approved gross patient service revenues. Blue Cross rate of payment and compliance with approved gross patient service revenues in the following manner:

(a) determining the sum of the comprehensive cancer center's noncapital inpatient and outpatient costs, in accordance with the principles of reimbursement for provider costs under 42 USC s.1395 et seq., and the medicare provider reimbursement manual, as projected prospectively and reported retrospectively by the comprehensive cancer center on the rate setting commission form 403, and as verified by audit. Add depreciation and interest and working capital recognized in hospital agreement thirty. Multiply the resulting amount by one plus the uniform statewide uncompensated care allowance;

(b) multiplying the total amount computed in clause (a) by one

hundred and seven per cent to yield the approved gross patient service revenue for the applicable fiscal year.

(c) reflecting any excess or deficit revenues earned in any fiscal year in the approved gross patient service revenue of the subsequent fiscal year.

If a comprehensive cancer center chooses to compute its gross patient service revenue in accordance with clauses (a) to (c), inclusive, a nonprofit hospital service corporation shall pay said comprehensive cancer center the lower of reasonable costs, which shall be defined as the total costs computed pursuant to clause (a) and as referenced in clause (b), or charges.

A comprehensive cancer center must elect to have its payments governed by this section within sixty days of the effective date of this section, or payments to the comprehensive cancer center shall be governed by sections seventy-nine to eighty-eight, inclusive.

Section 100. For purposes of this section, the following words shall have the following meanings, unless the context clearly requires otherwise:

"Eye and Ear Hospital", a hospital licensed under section fifty-one of chapter one hundred and eleven, which derives at least fifty per cent of its total annual revenue from the diagnosis and treatment of eye, ear, nose, throat and head and neck conditions.

Notwithstanding any contrary provision of law, for fiscal years nineteen hundred and eighty-eight, nineteen hundred and eighty-nine, nineteen hundred and ninety and nineteen hundred and ninety-one, an eye and ear hospital may, at its option, elect to establish, prospectively and retrospectively, its approved gross patient service revenue in the following manner:

(a) determining the sum of an eye and ear hospital's inpatient and outpatient noncapital costs, in accordance with the principles of reimbursement for provider costs under 42 USC s.1395 et seq., and the medicare provider reimbursement manual, as projected prospectively and reported retrospectively by the eye and ear hospital on the rate-setting commission form 403, and as verified by audit. Add to the amount of noncapital costs the hospital's patient care related depreciation interest and working capital defined pursuant to hospital agreement thirty. Multiply the sum of noncapital and capital costs by one plus the uniform statewide allowance for uncompensated care;

(b) multiplying the amount computed in clause (a) by one hundred and seven per cent to yield the approved gross patient service revenue.

The rate setting commission shall ensure the gross patient service revenues shall be generated without excess on shortfalls. Any excess or deficit of gross patient service revenue earned in any fiscal year will be reflected in the allowed gross patient service revenue of the subsequent year.

A nonprofit service corporation shall pay an eye and ear hospital based on the lower of: (1) the hospital's charges to the nonprofit hospital service corporation for services rendered, or (2) the nonprofit hospital service corporation's costs determined pursuant to medicare principles of cost apportionment, multiplied by one plus the uniform allowance for

uncompensated care.

An eye and ear hospital must elect to have its payments governed by this section within sixty days of the effective date of this section, or payments to the eye and ear hospital shall be governed by section seventy-nine to eighty-eight, inclusive.

Section 101. (a) There shall be within the executive office of human services an acute hospital conversion board, hereinafter referred to as "the board", consisting of the commissioner of public health or his designee, who shall serve as the chairman, the chairman of the rate setting commission or his designee, and the commissioner of the department of medical security or his designee. Said board shall administer the provisions of this section concerning the closing of acute hospitals or their conversion to other health, rehabilitative or public purposes. Said board shall provide assistance to acute hospitals in the identification and development of alternative financial resources and site uses, and in the expedition of state regulatory processes. Said board shall advise the division of employment security, the Massachusetts industrial service program and any other appropriate agencies or institutions regarding the need for reemployment training incentive programs for employees of acute hospitals whose employment is or will be terminated because of the closing or conversion of an acute hospital. Said board shall further have the authority to assist any closing or converting hospital in any other manner necessary and appropriate to ensure an orderly transition, including, but not limited to, ensuring that the hospital's obligations for any bonds issued and for other short and long-term debt are met.

(b) Any acute hospital which applies to the board shall qualify for relief pursuant to this section upon certifying to the board, with any supporting documentation that the board may require:

(1) that it intends to cease operation as an acute hospital by closing, by converting to another health, rehabilitative or other public purpose, or by ceasing to admit or care for patients in its medical-surgical, pediatric, obstetric and maternity beds, no later than twelve months following such certification; or

(2) that there is substantial doubt concerning whether the hospital will be able to continue as a going concern.

Upon receiving certification pursuant to this section of a hospital's intention to close or convert to another purpose, the board shall promptly notify the Massachusetts industrial service program established under chapter twenty-three D.

(c) Within thirty days of the receipt of such certification, the board shall appoint a community need determination committee to study the alternative needs of the community served by the hospital. Such committee shall consist of a trustee of the hospital, the mayor of the city or the head of the board of selectmen of the town in which the hospital is located, a physician with privileges at the hospital, a local representative of the elderly, a local member of the business community, a member of a collective bargaining unit of the hospital, a nurse employed at the hospital and a member of a regional health planning agency serving the community, if any. Such committee shall hold a

public hearing within sixty days of its appointment to determine the needs of the community for alternative health, rehabilitative and other public uses of the hospital facility. A report on such hearing shall be filed with the board.

(d) In the case of a hospital certifying its intention to close or convert:

(1) Notwithstanding the provisions of sections seventy-eight to ninety-eight, the board, if satisfied with the documentation provided, shall increase the amount of such hospital's patient care costs as determined pursuant to sections eighty to eighty-two A for its final twelve months of operation as an acute hospital to the extent necessary to allow for an orderly transition for the patients and employees of such hospital. Said board may also, to the extent necessary to make the closure or conversion financially feasible, permanently forgive any outstanding compliance liability pursuant to section eighty-five or its predecessor or successor section.

(2) The board shall further have the authority to exempt such closing or converting hospital or any hospital undertaking to purchase or merge with such closing or converting hospital from the provisions of sections twenty-five B to twenty-five G, inclusive, of chapter one hundred and eleven with regard to any substantial change in services, as defined in said sections and regulations pursuant thereto, proposed as a result of such closing or converting hospital's cessation of operation as an acute hospital; provided, however, that the board approves such proposal pursuant to this section; and provided, further, that the final outcome of any such exempted proposal shall be a net reduction in the number of medical-surgical, pediatric, obstetric and maternity beds equal to the number of such beds contained in such closing or converting hospital. The board shall consider the report of the community need determination committee established pursuant to paragraph (c) in determining whether to approve the hospital's proposal for a change in services.

The board shall approve any such proposal only if it finds that the proposed service will meet an identified health care need in such community; provided, however, that any such proposal which is not approved or disapproved within ninety days of its submission shall be deemed approved for purposes of this section and shall thereupon be exempt from the provisions of said sections twenty-five B to twenty-five G, inclusive, of chapter one hundred and eleven.

(e) In the case of a hospital certifying substantial doubt about its ability to continue as a going concern, notwithstanding the provisions of sections seventy-eight to ninety-eight, the board may increase the amount of the hospital's patient care costs as determined pursuant to sections eighty to eighty-two A, subject to the following conditions and limitations:

(1) The board may approve an increase only if it determines:

(i) that without rates of payment greater than those permitted pursuant to sections seventy-eight to ninety-eight, the hospital will be unable to continue to admit or care for patients in its medical-surgical, pediatric, obstetric and maternity beds; and

(ii) that the unavailability of said beds would necessarily seriously jeopardize the health and well-being of a significant number of persons.

(2) When making the determination required in clause (i) of subparagraph (1), the board shall identify all feasible alternative methods for relieving the hospital's financial distress, including but not limited to changes in the hospital's management personnel, expense reductions, closure of under-utilized or nonessential services, and merger and consolidation of services with neighboring hospitals.

(3) When making the determination required by clause (ii) of subparagraph (1), the board shall at a minimum, consider the report of the community need determination committee established pursuant to paragraph (c).

(4) Any increase shall be for a period of time to be specified by the board. The duration shall be the minimum necessary to enable the continued availability of essential medical-surgical, pediatric, obstetric and maternity beds, and shall not be indefinite.

(5) The amount of the increase shall be the minimum necessary to enable the continued availability of essential medical-surgical, pediatric, obstetric and maternity beds. In its determination of said amount, the board shall assume implementation of all feasible alternative methods identified pursuant to subparagraph (1), pursuant to the plan of action established pursuant to subparagraph (6).

(6) Any increase made pursuant to this section shall be contingent on the hospital's agreement to and continuing compliance with a plan of action approved by the board. Said plan of action shall specify the steps to be taken to make the hospital financially viable and able to provide essential services to its community. Said steps shall include all necessary changes in the hospital's management personnel and all feasible alternative methods identified pursuant to subparagraph (2).

(7) The board shall make said increase subject to such additional reasonable terms and conditions as it deems necessary and appropriate.

(8) If the plan of action includes steps requiring a determination pursuant to chapter one hundred and eleven, the board shall have the authority specified in subparagraph (2) of paragraph (d).

(f) Any acute hospital which qualifies for and receives relief pursuant to this section shall give its employees at least ninety days' prior written notice of the termination of their employment, such notice to be given in a form and manner prescribed by the board and to include at least the following: notice of their right to continued health benefits pursuant to statute or any applicable collective bargaining agreement; notice of their rights pursuant to sections seventy-one A to seventy-one J, inclusive, of chapter one hundred and fifty-one A; and notice of the availability of the comprehensive job placement and reemployment training program established pursuant to section four of chapter twenty-three D.

(g) In carrying out its duties pursuant to this section, the board shall seek the advice of an advisory council consisting of the following members: one representative each designated by the Massachusetts hospital association, the Massachusetts nurses' association, the Massachusetts health and educational facilities authority, and Blue Cross of Massachusetts, Inc.; a representative of a collective bargaining unit for hospital workers designated by the Massachusetts federation of labor-

congress of industrial organizations; and one representative each, to be appointed by the board, of the following: large teaching hospitals, community hospitals, large businesses, small businesses, commercial insurance companies, and health care consumers.

Section 102. Notwithstanding any provisions of this chapter to the contrary, all costs and charges for patients who are residents of other countries shall, as provided herein, be exempted from the limitations imposed by this chapter. Any hospital shall be allowed to impose a surcharge on the normal charges that would otherwise be allowed under this chapter for such residents of other countries. Such surcharges shall not be included in the calculation of gross patient service revenues. The normal charge and the patient discharge statistics shall otherwise be included under the provisions of this chapter. Blue Cross and the Massachusetts hospital association are hereby directed to submit a supplemental schedule which will become a part of the successor agreement to hospital agreement thirty to the commission for approval by no later than April first, nineteen hundred and eighty-eight.

SECTION 21. The first paragraph of section 4H of chapter 7 of the General Laws, as appearing in the 1986 Official Edition, is hereby amended by inserting after the word "six A", in line 11, the words:- and section five of chapter one hundred and seventy-six A.

SECTION 22. Chapter 15A of the General Laws is hereby amended by inserting after section 7A the following section:-

Section 7B. Effective September first, nineteen hundred and eighty-nine, every full time and part-time student enrolled in a public or independent institution of higher education located in the commonwealth shall participate in a qualifying student health insurance program. For the purposes of this section, "part-time student" shall mean a student participating in at least seventy-five per cent of the full time curriculum. Such an institution may elect to allow students to waive participation in its student health insurance program or any part thereof; provided, however, that an institution permitting such waivers shall require students waiving participation to certify in writing prior to any academic year in which they will not participate in the institution's plan that they are participating in a health insurance program having comparable coverages.

The department of medical security, with the advice and consent of the board of regents, shall issue regulations to define qualifying student health insurance programs, to establish procedures to monitor compliance, and to implement the provisions of this section.

Each public and independent institution of higher education shall submit an annual report to the department of medical security detailing its procedures for complying with the provisions of this section; provided, however, that prior to the implementation of this section the department of medical security and the board of regents shall submit a report to the house and senate committees on ways and means. Such report shall include, but not be limited, to an analysis of the number of students lacking health insurance, the costs of the requirements of this

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